

The HIV/AIDS Sustainability Index and Dashboard 2019 for Zimbabwe

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed every two years by PEPFAR and partner stakeholders to sharpen the understanding of each country's sustainability landscape and to assist PEPFAR and others in making informed HIV/AIDS investment decisions. Based on responses to 110 questions, the SID assesses the current state of sustainability of national HIV/AIDS responses across 17 critical elements. Scores for these elements are displayed on a color-coded dashboard, together with contextual charts and information. As the SID is completed over time, it will allow stakeholders to track progress and gaps across these key components of sustainability.

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| Dark Green Score (8.50-10 points) (sustainable and requires no additional investment at this time) |
| Light Green Score (7.00-8.49 points) (approaching sustainability and requires little or no investment) |
| Yellow Score (3.50-6.99 points) (emerging sustainability and needs some investment) |
| Red Score (<3.50 points) (unsustainable and requires significant investment) |

Country Overview

The PEPFAR country team and UNAIDS jointly collaborated with key partners including the Government of Zimbabwe (GoZ), members of the Global Fund's Country Coordination Mechanism (CCM), the United Nations Development Programme (UNDP), Clinton Health Access Initiative (CHAI), civil society core advocacy members, and other health development partners to develop SID 2019.

The National ART Program in Zimbabwe is implemented under the leadership of the Ministry of Health and Child Care (MoHCC), the Ministry of Primary and Secondary Education (MoPSE), and the Ministry of Labour and Social Welfare (MoLSW). Over the past several years there has been significant progress in the expansion of ART initiation and Zimbabwe is striving to achieve 95 percent ART coverage within all districts and across all age and sex bands by the end of FY20.

Despite significant strides, SID 2019 reflects broader sustainability challenges to achieving high ART coverage and epidemic control. These include continued economic instability and rising inflation, a low national budget allocation to health, human resource shortages, a deteriorating health system, poorly maintained infrastructure, and a heavy reliance on donor funding.

Stakeholder engagement around Zimbabwe's 2019 Responsibility Matrix reflected extensive donor funding reliance. PEPFAR and Global Fund invest in significant components of the national response including financing the purchase of test kits, ARVs and lab commodities, supporting the health workforce at both central and site levels, and contribute a significant portion of the efforts to strengthen laboratory services, supply chain and logistics systems.

| | | 2015 (SID 2.0) | 2017 (SID 3.0) | 2019 |
|--|--|----------------|----------------|------|
| SUSTAINABILITY DOMAINS AND ELEMENTS | Governance, Leadership, and Accountability | | | |
| | 1. Planning and Coordination | 9.33 | 10.00 | 8.57 |
| | 2. Policies and Governance | 7.16 | 7.11 | 5.82 |
| | 3. Civil Society Engagement | 6.17 | 6.46 | 3.00 |
| | 4. Private Sector Engagement | 2.71 | 5.92 | 5.92 |
| | 5. Public Access to Information | 8.00 | 5.00 | 4.67 |
| | National Health System and Service Delivery | | | |
| | 6. Service Delivery | 7.22 | 6.85 | 6.75 |
| | 7. Human Resources for Health | 8.42 | 8.40 | 7.76 |
| | 8. Commodity Security and Supply Chain | 6.14 | 6.14 | 4.81 |
| | 9. Quality Management | 8.67 | 8.67 | 9.33 |
| | 10. Laboratory | 4.72 | 5.50 | 6.89 |
| | Strategic Financing and Market Openness | | | |
| | 11. Domestic Resource Mobilization | 3.06 | 7.06 | 7.58 |
| | 12. Technical and Allocative Efficiencies | 6.70 | 8.56 | 8.56 |
| | 13. Market Openness | N/A | N/A | 6.88 |
| | Strategic Information | | | |
| 14. Epidemiological and Health Data | 3.87 | 4.51 | 5.18 | |
| 15. Financial/Expenditure Data | 7.08 | 10.00 | 10.00 | |
| 16. Performance Data | 7.34 | 7.12 | 7.56 | |
| 17. Data for Decision-Making Ecosystem | N/A | N/A | 5.00 | |

SID Process

PEPFAR Zimbabwe and USAIDS jointly engaged a diverse group of stakeholders and co-convoked a 2 day workshop to inform SID 2019 with the aim of advancing our shared goal of sustainability. Participants engaged in completing Zimbabwe's SID included members from MOHCC, NAC, MOF, CHAI, SAFAIDS, EGPAF, DFID, ZNNP+, UN Joint team and a diverse group of key stakeholders including civil society, FBOs and NGOs, and representatives from the donor community.

Sustainability Strengths

Sustainability strengths and vulnerabilities identified as part of SID 2019 include the following:

- Planning and coordination (Element 1, Score **8.57**): The MOHCC develops and implements a costed multiyear national strategy and serves as the convener of a coordinated HIV/AIDS response. Policies, guidelines and SOPs exist within the national response, but require greater oversight and stronger implementation.
- Quality management (Element 9, Score **9.33**): Stakeholders consulted cited strong institutionalized quality management systems, plans, workforce capacities, and other key inputs to ensure that quality improvement methodologies are applied to managing and providing HIV/AIDS services. HIV program performance measurement data are systematically collected and analyzed to identify areas of patient care and services that can be continuously improved.

- Technical and allocative efficiencies (Element 12, Score 8.56): There is a demonstrated commitment among stakeholders to use relevant HIV/AIDS epidemiological, health, and economic data to inform HIV/AIDS investment decisions.
- Financial/expenditure data (Element 15, Score 10.0): The government remains committed to collect, track, and analyze available financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS expenditures.

Sustainability Vulnerabilities

- Commodity Security and Supply Chain (Element 8, Score 4.81): The GoZ has established a successful AIDS levy to procure ARVs and support other program activities. However, the value of these funds has declined over the past two years as inflation has risen and the procurement of ARVs, HIV rapid test kits, and condoms is heavily dependent on donor funding. National contributions to supply chain financing are largely limited to health workforce and infrastructure. Multiple stakeholders and members from diverse CSOs expressed concern regarding a “weaknesses in the supply chain”. This concern was not regarding a reliance or dependence on donors for commodity procurement. Stakeholders were concerned about NatPharm mismanagement and poor performance when it came to the delivery of commodities to facilities.
- Civil Society Engagement (Element 3, Score 3.00): Stakeholders consulted cited concerns regarding civil society engagement. Laws exist that indirectly restrict civil society from playing an oversight role in the HIV/AIDS response. There are opportunities for civil society groups to engage and provide feedback on HIV/AIDS policies and programs, however, this input is solicited in an ad hoc manner. Minimal funding (under 9%) for HIV/AIDS related civil society organizations comes from domestic sources and there are currently no laws and policies in place which provide for CSOs to receive funding from a government budget for HIV services through open competition.

Key components of the national program are primarily driven by donor funding. There is funding within the domestic program and via the AIDS levy and health levy from mobile networks that needs to be better aligned to reach targets to achieve epidemic control.

PEPFAR will continue to coordinate with the GoZ, the Global Fund, as well as other donors in the health sector to ensure that investments are complimentary and that PEPFAR contributions are maximized towards achieving epidemic control.

Contact

For questions about PEPFAR’s efforts to support sustainability in Zimbabwe please contact Kristine Clark (email: ClarkKF@state.gov) and Judith Chaumba (email: ChaumbaJT@state.gov) in the PEPFAR Coordination Office.

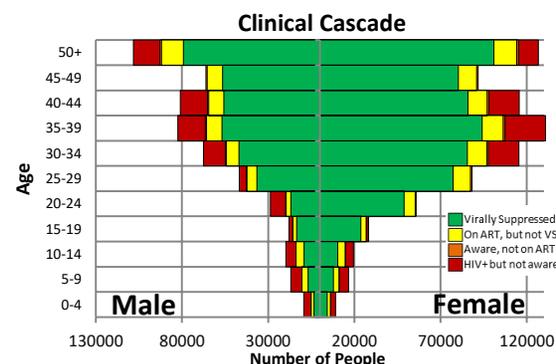
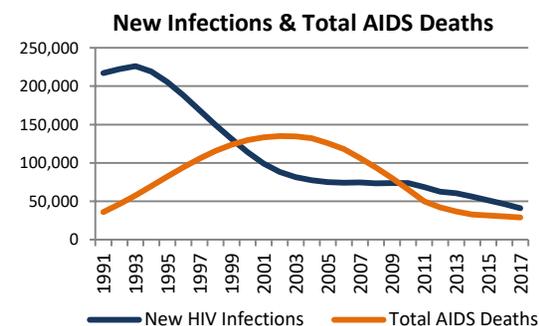
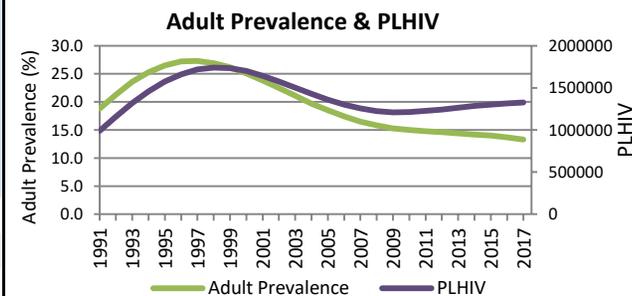
Sustainability Analysis for Epidemic Control: Zimbabwe

Epidemic Type: Generalized
 Income Level: Lower middle income
 PEPFAR Categorization: Long-term Strategy
 PEPFAR COP 19 Planning Level: 162,947,750

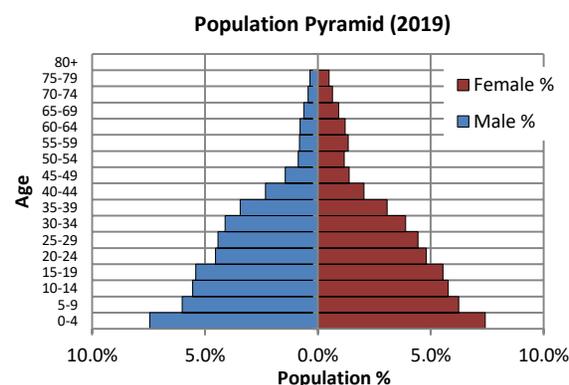
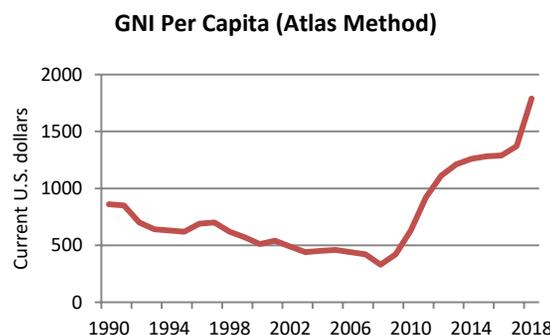
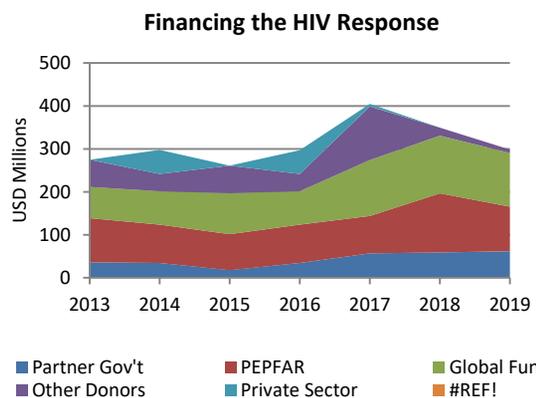
SUSTAINABILITY DOMAINS AND ELEMENTS

| | 2015 (SID 2.0) | 2017 (SID 3.0) | 2019 | 2021 |
|--|----------------|----------------|-------|------|
| Governance, Leadership, and Accountability | | | | |
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CONTEXTUAL DATA



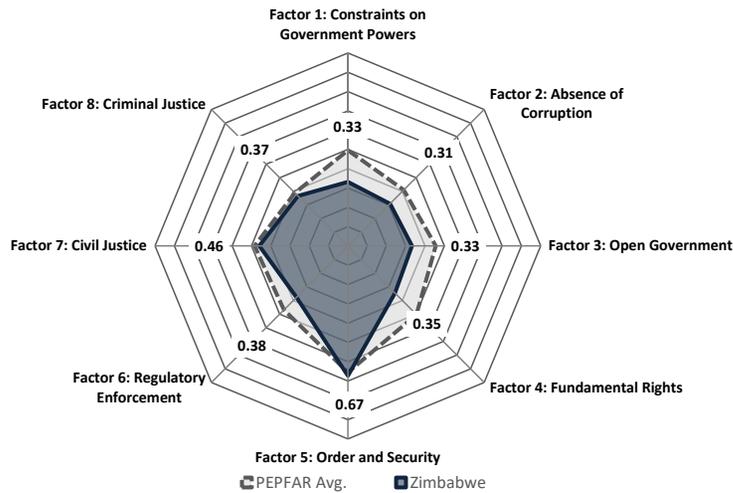
CONTEXTUAL DATA



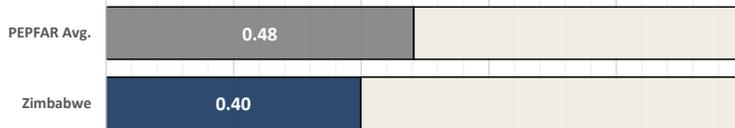
Sustainability Analysis for Epidemic Control: Zimbabwe

Contextual Governance Indicators

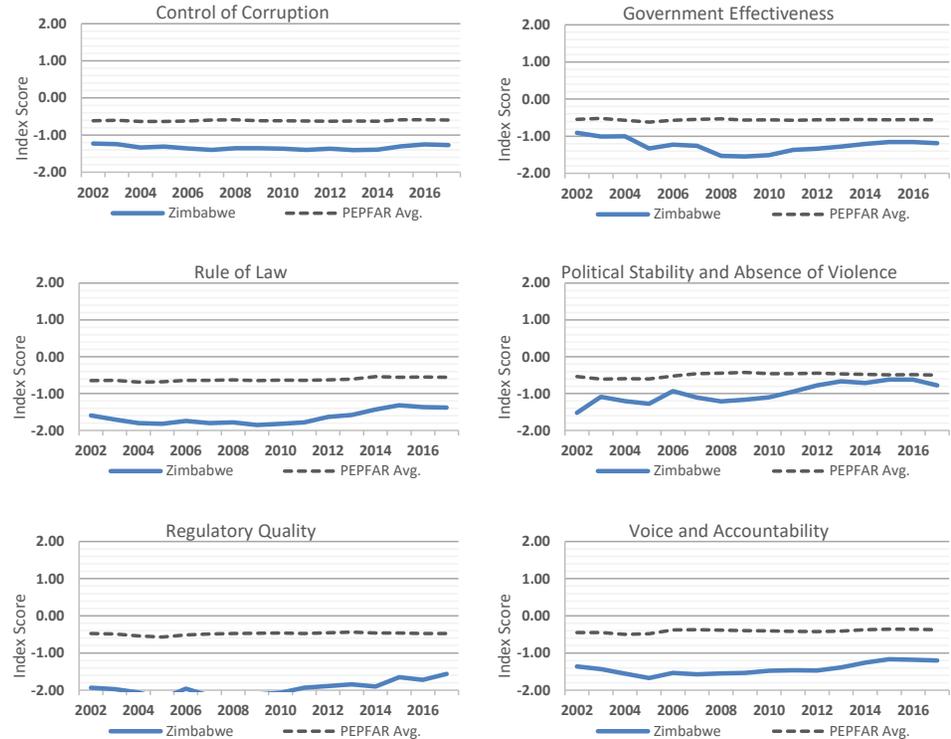
Rule of Law Index (World Justice Project)



Overall WJP Rule of Law Index Score



Worldwide Governance Indicators (World Bank)



WJP's Rule of Law Index measures the general public's experience and perception across eight 'factors':

- 1. Constraints on Government Powers:** Governmental powers are limited by both internal and external checks, including auditing and review. Governmental officials are subject to the law and sanctioned for misconduct.
- 2. Absence of Corruption:** Government officials in all branches of government do not use public office for private gain.
- 3. Open Government:** Citizens have open access to government information and data, complaint mechanisms, and civic participation.
- 4. Fundamental Rights:** There is equal treatment of citizens and absence of discrimination. The rights to freedom of expression, security of the person, and due process are effectively guaranteed.
- 5. Order and Security:** Crime and civil conflict are effectively limited. Personal grievances are not redressed through violence.
- 6. Regulatory Enforcement:** Government regulations are effectively applied and enforced without improper influence. Due process is respected in administrative proceedings.
- 7. Civil Justice:** Civil justice is accessible and free of discrimination, corruption and improper government influence.
- 8. Criminal Justice:** Criminal justice is impartial, timely and effective, and free from corruption or improper government influence. There is due process of law and rights of the accused.

More information can be found at: <https://worldjusticeproject.org/our-work/research-and-data/wjp-rule-law-index-2019>

The World Bank Worldwide Governance Indicators (WGI) score countries based on six dimensions of governance:

- 1. Control of Corruption:** captures perceptions of the extent to which public power is exercised for private gain, including both petty and grand forms of corruption, as well as 'capture' of the state by elites and private interests.
- 2. Government Effectiveness:** measures the quality of public services, the quality of the civil service and its independence from political pressure, the quality of policy formulation and implementation (including the efficiency of revenue mobilization and budget management), and the credibility of the government's commitment to its stated policies.
- 3. Rule of Law:** captures perceptions of the extent to which agents have confidence in and abide by the rules of society, and in particular the quality of contract enforcement, property rights, the police, and the courts, as well as the likelihood of crime and violence.
- 4. Political Stability and Absence of Violence:** measures perceptions of the likelihood of political instability and/or politically-motivated violence, including terrorism.
- 5. Regulatory Quality:** Measures perceptions of the ability of the government to formulate and implement sound policies and regulations that permit and promote private sector development.
- 6. Voice and Accountability:** captures perceptions of the extent to which a country's citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media.

More information can be found at: <https://info.worldbank.org/governance/wgi/>

Domain A. Governance, Leadership, and Accountability

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, provides accurate information and education on HIV/AIDS, and supports mechanisms for eliciting feedback. Relevant government entities take actions to create an enabling policy and legal environment, ensure good stewardship of HIV/AIDS resources, create space for and promote participation of the private sector, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

| 1. Planning and Coordination: Host country develops, implements, and oversees a costed multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector. | Data Source | Notes/Comments |
|---|------------------------|---|
| <p>1.1 Content of National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?</p> | <p>1.1 Score: 2.07</p> | <p>Zimbabwe National HIV/AIDS Strategic Plan (ZNASP) III Extended Version (2015-2020)</p> <p>The MOHCC develops and implements a costed multiyear national strategy and serves as the convener of a coordinated HIV/AIDS response. Policies, guidelines and SOPs exist within the national response, but require greater oversight and stronger implementation.</p> |
| <p><input type="radio"/> A. There is no national strategy for HIV/AIDS</p> <p><input checked="" type="radio"/> B. There is a multiyear national strategy. Check all that apply:</p> <p><input checked="" type="checkbox"/> It is costed</p> <p><input checked="" type="checkbox"/> It has measurable targets.</p> <p><input checked="" type="checkbox"/> It is updated at least every five years</p> <p>Strategy includes all crucial response components for prevention and treatment (HIV testing, treatment and care [including children and adolescents], PMTCT, transition from 'catchup' to sustainable VMMC if country performs VMMCs, scale-up of viral load, EID, and other key metrics)</p> <p><input type="checkbox"/> Strategy includes explicit plans and activities to address the needs of key populations.</p> <p><input checked="" type="checkbox"/> Strategy includes all crucial response components to mitigate the impact of HIV on vulnerable children</p> <p><input type="checkbox"/> Strategy (or separate document) includes considerations and activities related to sustainability</p> | | |

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|---|--|------------------------|---|---|
| <p>1.2 Participation in National Strategy Development: Who actively participates in development of the country's national HIV/AIDS strategy?</p> | <p><input type="radio"/> A. There is no national strategy for HIV/AIDS</p> <p><input checked="" type="radio"/> B. The national strategy is developed with participation from the following stakeholders (check all that apply):</p> <p><input checked="" type="checkbox"/> Its development was led by the host country government</p> <p><input checked="" type="checkbox"/> Civil society actively participated in the development of the strategy</p> <p><input type="checkbox"/> Private health sector providers, facilities, and training institutions, actively participated in the development of the strategy</p> <p><input checked="" type="checkbox"/> Businesses and the corporate sector actively participated in the development of the strategy including workplace development and corporate social responsibility (CSR)</p> <p><input checked="" type="checkbox"/> External agencies (i.e. donors, other multilateral orgs., etc.) supporting HIV services in-country participated in the development of the strategy</p> | <p>1.2 Score: 2.00</p> | <p>1. Zimbabwe National HIV/AIDS Strategic Plan (ZNASP) III Extended Version (2015-2020) 2. ZNASP development reports and minutes</p> | <p>Limited consultation and participation by CSOs, private health sector, and business/corporate sector.</p> |
| <p>1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS activities implemented in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners?</p> | <p>Check all that apply:</p> <p><input checked="" type="checkbox"/> There is an effective mechanism within the host country government for internally coordinating HIV/AIDS activities implemented by various government ministries, institutions, offices, etc.</p> <p><input checked="" type="checkbox"/> The host country government routinely tracks and maps HIV/AIDS activities of:</p> <p><input checked="" type="checkbox"/> civil society organizations</p> <p><input type="checkbox"/> private sector (including health care providers and/or other private sector partners)</p> <p><input checked="" type="checkbox"/> donors</p> <p><input checked="" type="checkbox"/> The host country government leads a mechanism or process (i.e. committee, working group, etc.) that routinely convenes key internal and external stakeholders and implementers of the national response for planning and coordination purposes.</p> <p><input checked="" type="checkbox"/> Joint operational plans are developed that include key activities of implementing organizations.</p> <p><input type="checkbox"/> Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed.</p> | <p>1.3 Score: 2.00</p> | <p>1. NAC quarterly reports 2. MOH Technical Working Group reports 3. CCM reports and minutes</p> | <p>Coordination most effective at Provincial and District levels through the PAAC and DAACs. TWGs are not entirely inclusive.</p> |

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| <p>1.4 Sub-national Unit Accountability: Is there a mechanism by which sub-national units are accountable to national HIV/AIDS goals or targets? (note: equal points for either checkbox under option B)</p> | <p><input type="radio"/> A. There is no formal link between the national plan and sub-national service delivery.</p> <p><input checked="" type="radio"/> B. There is a formal link between the national plan and sub-national service delivery. (Check the ONE that applies.)</p> <p><input checked="" type="checkbox"/> Sub-national units have performance targets that contribute to aggregate national goals or targets.</p> <p><input type="checkbox"/> The central government is responsible for service delivery at the sub-national level.</p> | <p>1.4 Score: 2.50</p> | <p>Annual District Integrated Plans; Annual NAC Reports</p> | |
| <p>Planning and Coordination Score: 8.57</p> | | | | |

| 2. Policies and Governance: Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response. | | Data Source | Notes/Comments |
|---|--|------------------------|---|
| <p>2.1 WHO Guidelines for ART Initiation: Does current national HIV/AIDS technical practice follow current WHO guidelines for initiation of ART - i.e., optimal ART regimens for all populations (including TLD as recommended)?</p> | <p>For each category below, check yes or no to indicate if current national HIV/AIDS technical practice follows current WHO guidelines on optimal ART regimens for each of the following:</p> <p>A. Adults (>19 years)</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>B. Pregnant and Breastfeeding Mothers</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>C. Adolescents (10-19 years)</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>D. Children (<10 years)</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> | <p>2.1 Score: 0.91</p> | <p>Operational and Service Delivery Manual 2017</p> |

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|---|---|------------------------|--|--|
| <p>2.2 Enabling Policies and Legislation: Are there policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care which is inclusive of HIV service delivery?</p> <p>Note: If one of the listed policies differentiates policy for specific groups, please note in the Notes/Comments column.</p> | <p>Check all that apply:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> A national public health services act that includes the control of HIV <input checked="" type="checkbox"/> A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART <input checked="" type="checkbox"/> A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits <input checked="" type="checkbox"/> Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months) <input checked="" type="checkbox"/> Policies that permit patients stable on ART to have reduced ARV pickups (i.e. every 3-6 months) <input checked="" type="checkbox"/> Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready <input checked="" type="checkbox"/> Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS <input checked="" type="checkbox"/> Policies that permit HIV self-testing <input checked="" type="checkbox"/> Policies that permit pre-exposure prophylaxis (PrEP) <input checked="" type="checkbox"/> Policies that permit post-exposure prophylaxis (PEP) <input checked="" type="checkbox"/> Policies that allow HIV testing without parental consent for adolescents, starting at age 15 <input checked="" type="checkbox"/> Policies that allow HIV-infected adolescents, starting at age 15, to seek HIV treatment without parental consent | <p>2.2 Score: 0.91</p> | <p>1. National AIDS Council Act of 1999 2. Children's Act Various Guidelines</p> | <p>3. Most of the checked policies are Guidelines or SOPs. Children's Act protection not specific to HIV/AIDS.</p> |
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| <p>2.3 User Fees for HIV Services: Are HIV infected persons expected or likely to be asked to pay user fees, either formal or informal, for <u>any</u> HIV services in the public sector: clinical, laboratory, testing, prevention and others?</p> <p>Note: "Formal" user fees are those established in policy or regulation by a government or institution.</p> | <p>Check all that apply:</p> <p><input type="checkbox"/> No, neither formal nor informal user fees exist.</p> <p><input checked="" type="checkbox"/> Yes, formal user fees exist.</p> <p><input checked="" type="checkbox"/> Yes, informal user fees exist.</p> | <p>2.3 Score: 0.00</p> | <p>Discussion with multiple stakeholders during SID consultations</p> | <p>Example of fees include: shipment fees; administration fees; stamping fees; and security fees. Most fees charged by local government/council health facilities.</p> |
| <p>2.4 User Fees for Other Health Services: Are HIV infected persons expected or likely to be asked to pay user fees, either formal or informal, for <u>any</u> non-HIV services in the public sector, such as MCH/SRH, TB, outpatient registration, hospitalizations, and others?</p> <p>Note: "Formal" user fees are those established in policy or regulation by a government or institution.</p> | <p>Check all that apply:</p> <p><input type="checkbox"/> No, neither formal nor informal user fees exist.</p> <p><input checked="" type="checkbox"/> Yes, formal user fees exist.</p> <p><input checked="" type="checkbox"/> Yes, informal user fees exist.</p> | <p>2.4 Score: 0.00</p> | <p>Discussion with multiple stakeholders during SID consultations</p> | <p>Example of fees include: shipment fees; administration fees; and stamping fees.</p> |
| <p>2.5 Data Protection: Does the country have policies in place that support the collection and appropriate use of patient-level data for health, including HIV/AIDS?</p> | <p>The country has policies in place that (check all that apply):</p> <p><input checked="" type="checkbox"/> Govern the collection of patient-level data for public health purposes, including surveillance</p> <p><input type="checkbox"/> Govern the collection and use of unique identifiers such as national ID for health records</p> <p><input checked="" type="checkbox"/> Govern the privacy and confidentiality of health outcomes matched with personally identifiable information</p> <p><input checked="" type="checkbox"/> Govern the use of patient-level data, including protection against its use in criminal cases</p> | <p>2.5 Score: 0.68</p> | <p>1. National Health Policy 2. Public Health Act 3. Discussion with multiple stakeholders during SID consultations</p> | |

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| <p>2.6 Legal Protections for Key Populations: Does the country have laws or policies that specify protections (not specific to HIV) for specific populations?</p> | <p>Check all that apply:</p> <p>Transgender people (TG):</p> <p><input type="checkbox"/> Constitutional prohibition of discrimination based on gender diversity</p> <p><input type="checkbox"/> Prohibitions of discrimination in employment based on gender diversity</p> <p><input type="checkbox"/> A third gender is legally recognized</p> <p><input type="checkbox"/> Other non-discrimination provisions specifying gender diversity (note in comments)</p> <p>Men who have sex with men (MSM):</p> <p><input type="checkbox"/> Constitutional prohibition of discrimination based on sexual orientation</p> <p><input type="checkbox"/> Hate crimes based on sexual orientation are considered an aggravating circumstance</p> <p><input type="checkbox"/> Incitement to hatred based on sexual orientation prohibited</p> <p><input type="checkbox"/> Prohibition of discrimination in employment based on sexual orientation</p> <p><input type="checkbox"/> Other non-discrimination provisions specifying sexual orientation</p> <p>Female sex workers (FSW):</p> <p><input type="checkbox"/> Constitutional prohibition of discrimination based on occupation</p> <p><input type="checkbox"/> Sex work is recognized as work</p> <p><input type="checkbox"/> Other non-discrimination protections specifying sex work (note in comments)</p> | <p>2.6 Score: 0.08</p> | <p>Zimbabwe National HIV/AIDS Strategic Plan (ZNASP) III Extended Version (2015-2020)</p> | <p>Multiple stakeholders mentioned that where laws and policies are available they may not be fully implemented or implemented inconsistently. For example, no clear policy exists for CSWs. CSWs should not be targeted for loitering without clear evidence, yet continue to be persecuted. Constitution does not factor gender diversity and sexual orientation issues. The constitution recognizes 2 genders: male and female.</p> |
|--|---|------------------------|---|--|

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|--|--|------------------------|---|--|
| | <p>People who inject drugs (PWID):</p> <p><input type="checkbox"/> Specific antidiscrimination laws or other provisions for people who use drugs (specify in comments)</p> <p><input checked="" type="checkbox"/> Explicit supportive reference to harm reduction in national policies</p> <p><input type="checkbox"/> Policies that address the specific needs of women who inject drugs</p> | | | |
| <p>2.7 Legal Protections for Victims of Violence: Does the country have protections in place for victims of violence?</p> | <p>The country has the following to protect key populations and people living with HIV (PLHIV) from violence:</p> <p><input checked="" type="checkbox"/> General criminal laws prohibiting violence</p> <p><input checked="" type="checkbox"/> Specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population</p> <p><input checked="" type="checkbox"/> Programs to address intimate partner violence</p> <p><input checked="" type="checkbox"/> Programs to address workplace violence</p> <p><input type="checkbox"/> Interventions to address police abuse</p> <p><input checked="" type="checkbox"/> Interventions to address torture and ill treatment in prisons</p> <p><input checked="" type="checkbox"/> A national plan or strategy to address gender-based violence and violence against women that includes HIV</p> <p><input checked="" type="checkbox"/> Legislation on domestic violence</p> <p><input checked="" type="checkbox"/> Criminal penalties for domestic violence</p> <p><input checked="" type="checkbox"/> Criminal penalties for violence against children</p> | <p>2.7 Score: 0.82</p> | <p>Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question. Sources include:</p> <ol style="list-style-type: none"> 1. Domestic Violence Act 2. Child Protection Act 3. Zimbabwe HIV/AIDS Human Rights Charter 4. Discussion with multiple stakeholders during SID consultations | <p>Specific legal provisions exist prohibiting violence against people based on their HIV status but not specifically for key populations. No national laws exist on workplace violence.</p> |

2.8 Structural Obstacles: Does the country have laws and/or policies that present barriers to delivery of HIV prevention, testing and treatment services or the accessibility of these services?

For each question, select the most appropriate option:

Are transgender people criminalized and/or prosecuted in the country?

- Both criminalized and prosecuted
- Criminalized
- Prosecuted
- Neither criminalized nor prosecuted

Is cross-dressing criminalized in the country?

- Yes
- Yes, only in parts of the country
- Yes, only under certain circumstances
- No

Is sex work criminalized in your country?

- Selling and buying sexual services is criminalized
- Selling sexual services is criminalized
- Buying sexual services is criminalized
- Partial criminalization of sex work
- Other punitive regulation of sex work
- Sex work is not subject to punitive regulations or is not criminalized.
- Issue is determined/differs at subnational level

2.8 Score:

0.61

Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question. Sources include: Discussion with multiple stakeholders during SID consultations

Does the country have laws criminalizing same-sex sexual acts?

- Yes, death penalty
- Yes, imprisonment (14 years - life)
- Yes, imprisonment (up to 14 years)
- No penalty specified
- No specific legislation
- Laws penalizing same-sex sexual acts have been decriminalized or never existed

Does the country maintain the death penalty in law for people convicted of drug-related offenses?

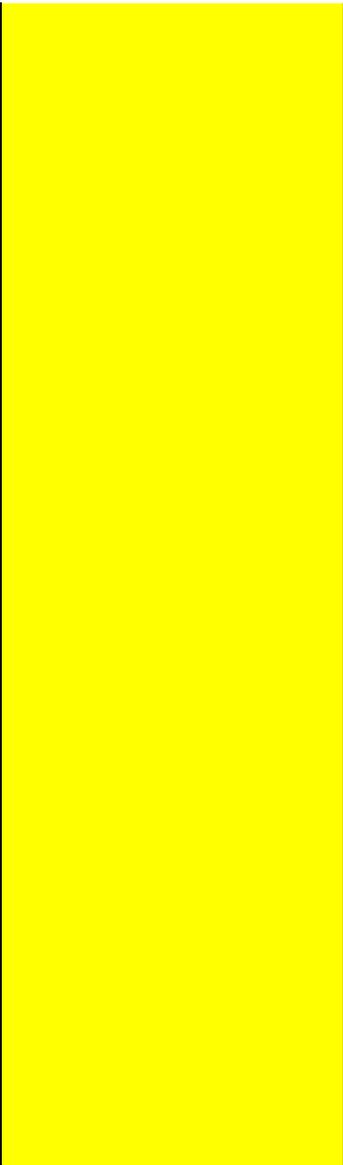
- Yes, with high application (sentencing of people convicted of drug offenses to death and/or carrying out executions are a routine and mainstreamed part of the criminal justice system)
- Yes, with low application (executions for drug offenses may have been carried out in recent years, but in practice such penalties are relatively rare)
- Yes, with symbolic application (the death penalty for drug offenses is included in legislation, but executions are not carried out)
- No

Does the country have laws criminalizing the transmission of, non-disclosure of, or exposure to HIV transmission?

- Yes
- No, but prosecutions exist based on general criminal laws
- No

Does the country have policies restricting the entry, stay, and residence of people living with HIV (PLHIV)?

- Yes
- No

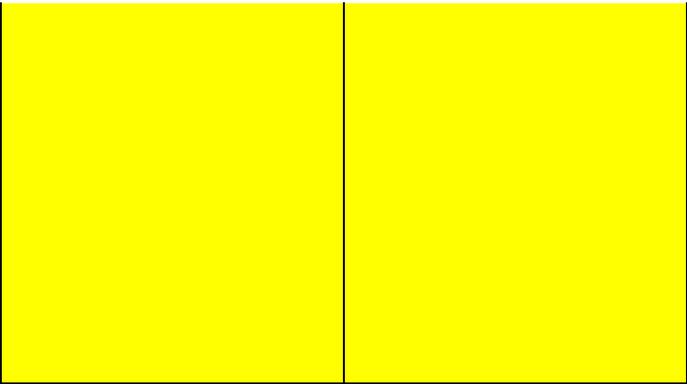


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| | <p>Does the country have other punitive laws affecting lesbian, gay, bisexual, transgender, and intersex (LGBTI) people?</p> <p><input type="checkbox"/> Yes, promotion ("propaganda") laws</p> <p><input checked="" type="checkbox"/> Yes, morality laws or religious norms that limit LGBTI freedom of expression and association</p> <p><input type="checkbox"/> No</p> | | | |
| <p>2.9 Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, adolescents, and those who may access HIV services about these rights?</p> | <p>There are host country government efforts in place as follows (check all that apply):</p> <p><input checked="" type="checkbox"/> To educate PLHIV about their legal rights in terms of access to HIV services</p> <p><input checked="" type="checkbox"/> To educate key populations about their legal rights in terms of access to HIV services</p> <p><input checked="" type="checkbox"/> National law exists regarding health care privacy and confidentiality protections</p> <p><input type="checkbox"/> Government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found</p> | <p>2.9 Score: 0.91</p> | <p>Sources include:</p> <ol style="list-style-type: none"> 1. Constitution of Zimbabwe 2013 2. Public Health ACT Amendment Bill 2018 3. Discussion with multiple stakeholders during SID consultations | <p>Key populations have varied reach and policies available. Government provides legal representation and not financial support.</p> |
| <p>2.10 Audit: Does the host country government conduct a national HIV/AIDS program audit or audit of Ministries that work on HIV/AIDS on a regular basis (excluding audits of donor funding that are through government financial systems)?</p> | <p><input type="radio"/> A. No audit is conducted of the National HIV/AIDS Program or other relevant ministry.</p> <p><input type="radio"/> B. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 4 years or more.</p> <p><input checked="" type="radio"/> C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less.</p> | <p>2.10 Score: 0.91</p> | <p>Sources include:</p> <ol style="list-style-type: none"> 1. ZNASP mid-term and end evaluation report 2. Annual NAC Audit Report 3. Auditor and Controller General Annual Audit Report | |
| <p>2.11 Audit Action: To what extent does the host country government respond to the findings of a HIV/AIDS audit or audit of Ministries that work on HIV/AIDS?</p> | <p><input checked="" type="radio"/> A. Host country government does not respond to audit findings, or no audit of the national HIV/AIDS program is conducted.</p> <p><input type="radio"/> B. The host country government does respond to audit findings by implementing changes as a result of the audit.</p> <p><input type="radio"/> C. The host country government does respond to audit findings by implementing changes which can be tracked by legislature or other bodies that hold government accountable.</p> | <p>2.11 Score: 0.00</p> | <p>Sources include:</p> <ol style="list-style-type: none"> 1. MOHCC 2. Auditor and Controller General 3. Annual Audit Report | <p>Implementing audit findings is challenged by a legal framework that has not changed or adapted as needed. Audits are done, but there is limited implementation of findings and limited tracking by legislature or other bodies.</p> |
| Policies and Governance Score: | | 5.82 | | |

| 3. Civil Society Engagement: Local civil society is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, and as a key stakeholder to inform the national HIV/AIDS response. There are mechanisms for civil society to review and provide feedback regarding public programs, services and fiscal management and civil society is able to hold government institutions accountable for the use of HIV/AIDS funds and for the results of their actions. | | | |
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| | Data Source | Notes/Comments | |
| <p>3.1 Civil Society and Accountability for HIV/AIDS: Are there any laws or policies that restrict civil society from playing an oversight role in the HIV/AIDS response?</p> | <p>3.1 Score: 0.00</p> <p>1. Zimbabwe National HIV/AIDS Strategic Plan (ZNASP) 2. Access to Information and Protection of Privacy Act (AIPPA) 3. Public Order Security Act (POSA)</p> | <p>Stakeholders consulted cited concerns regarding civil society engagement. Laws exist that indirectly restrict civil society from playing an oversight role in the HIV/AIDS response. There are opportunities for civil society groups to engage and provide feedback on HIV/AIDS policies and programs, however, this input is solicited in an ad hoc manner. Minimal funding (under 9%) for HIV/AIDS related civil society organizations comes from domestic sources and there are currently no laws and policies in place which provide for CSOs to receive funding from a government budget for HIV services through open competition. Although the respective laws are currently being reviewed, most of the current limitations (described as draconian provisions by stakeholders) remain in the new laws. In SID 2017 stakeholders consulted selected response C.</p> | |
| <p>3.2 Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels or opportunities for diverse civil society groups to</p> | <p>3.2 Score: 0.83</p> <p>Discussion with multiple stakeholders during SID consultations.</p> | <p>In SID 2017 stakeholders consulted selected response C.</p> | |

engage and provide feedback on its HIV/AIDS policies, programs, and services (not including Global Fund CCM civil society engagement requirements)?

- For policy development
- As members of technical working groups
- Involvement on government HIV/AIDS program evaluation teams
- Involvement in surveys/studies
- Collecting and reporting on client feedback
- Service delivery



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| <p>3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy, programming, and budget decisions related to HIV/AIDS?</p> | <p>A. Civil society does not actively engage, or civil society engagement does not impact policy, programming, and budget decisions related to HIV/AIDS.</p> <p><input type="radio"/></p> <p><input checked="" type="radio"/> B. Civil society's engagement impacts HIV/AIDS policy, programming, and budget decisions (check all that apply):</p> <p><input checked="" type="checkbox"/> In policy design</p> <p><input checked="" type="checkbox"/> In programmatic decision making</p> <p><input checked="" type="checkbox"/> In technical decision making</p> <p><input checked="" type="checkbox"/> In service delivery</p> <p><input type="checkbox"/> In HIV/AIDS basket or national health financing decisions</p> | <p>3.3 Score: 1.33</p> | <p>Discussion with multiple stakeholders during SID consultations</p> | <p>In certain instances, but not all. However CSO reps present noted that there is more of token participation as they get involved at advanced stages of policy/guideline formulation</p> |
| <p>3.4 Domestic Funding of Civil Society: To what extent are HIV/AIDS related Civil Society Organizations funded domestically (either from government, private sector, or self generated funds)?</p> <p>(if exact or approximate overall percentage known, or the percentages from the various domestic sources, please note in Comments column)</p> | <p><input type="radio"/> A. No funding (0%) for HIV/AIDS related civil society organizations comes from domestic sources.</p> <p><input checked="" type="radio"/> B. Minimal funding (approx. 1-9%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).</p> <p><input type="radio"/> C. Some funding (approx. 10-49%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).</p> <p><input type="radio"/> D. Most funding (approx. 50-89%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).</p> <p><input type="radio"/> E. All or almost all funding (approx. 90%+) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).</p> | <p>3.4 Score: 0.83</p> | <p>1. NATF report 2. CSO membership subscriptions reports</p> | <p>Most of the domestic financing for CSOs is through membership subscriptions and donations from corporates on an ad hoc basis. Other CSOs have grants from the NATF.</p> |
| <p>3.5 Civil Society Enabling Environment: Are there laws, policies, or regulations in place which permit CSOs to be funded from a government budget for HIV services through open competition (from any Ministry or Department, at any level - national, regional, or local)?</p> <p>Note: This sometimes referred to as "social contracting" or "social procurement."</p> | <p><input checked="" type="radio"/> A. There is no law, policy, or regulation which permits CSOs to be funded from a government budget for HIV Services through open competition (not to include Global Fund or other donor funding to government that goes to CSOs).</p> <p><input type="radio"/> B. There is a law, policy or regulation which permits CSOs to be funded from a government budget for HIV services. Check all that apply:</p> <p><input type="checkbox"/> Competition is open and transparent (notices of opportunities are made public)</p> <p><input type="checkbox"/> Opportunities for CSO funding are made on an annual basis</p> <p><input type="checkbox"/> Awards are made in a timely manner (within 6-12 months of announcements)</p> <p><input type="checkbox"/> Payments are made to CSOs on time for provision of services</p> | <p>3.5 Score: 0.00</p> | <p>No law or policy in place</p> | <p>In SID 2017 stakeholders consulted selected response B.</p> |
| <p>Civil Society Engagement Score:</p> | | <p>3.00</p> | | |

| 4. Private Sector Engagement: Global as well as local private sector (both private health care providers and private business) is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, innovation, and as a key stakeholder to inform the national HIV/AIDS response. There are supportive policies and mechanisms for the private sector to engage and to review and provide feedback regarding public programs, services and fiscal management of the national HIV/AIDS response. The public uses the private sector for HIV service delivery at a similar level as other health care needs. | | | Data Source | Notes/Comments |
|---|---|------------------------|---|----------------|
| <p>4.1 Government Channels and Opportunities for Private Sector Engagement: Does the host country government have formal channels and opportunities for diverse private sector entities (including service delivery, corporations, and private training institutions) to engage and provide feedback on its HIV/AIDS policies, programs, and services?</p> <p>(If option B is true, check all subsequent boxes that apply.)</p> | <p><input type="radio"/> A. There are no formal channels or opportunities for private sector engagement.</p> <p><input checked="" type="radio"/> B. There are formal channels or opportunities for private sector engagement.</p> <p>i. The following private sector stakeholders formally contribute input into national or sub-national processes for HIV/AIDS planning and strategic development (check all that apply):</p> <p><input checked="" type="checkbox"/> Corporations</p> <p><input checked="" type="checkbox"/> Employers</p> <p><input checked="" type="checkbox"/> Private training institutions</p> <p><input checked="" type="checkbox"/> Private health service delivery providers</p> <p>ii. Stakeholders contribute in the following ways (check all that apply):</p> <p><input checked="" type="checkbox"/> The private sector contributes technical expertise into HIV program planning</p> <p><input checked="" type="checkbox"/> Data and strategic input into supply chain management for HIV commodities</p> <p><input checked="" type="checkbox"/> Service delivery and/or client satisfaction data from private service delivery providers is included in health sector and HIV program planning</p> <p><input checked="" type="checkbox"/> Data on staffing in private health service delivery providers</p> <p><input checked="" type="checkbox"/> Data on private training institution's human resources for health (HRH) graduates and placements are included in health sector and HIV program planning</p> <p><input checked="" type="checkbox"/> For technical advisory on best practices and delivery solutions</p> | <p>4.1 Score: 2.22</p> | <p>1. Private Sector Board Terms of Reference 2. Zimbabwe National HIV/AIDS Strategic Plan (ZNASP) III Extended Version (2015-2020)</p> | |

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| | <p>iii. The national HIV/AIDS strategic plan explicitly addresses private sector's role in the HIV/AIDS response (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> The national HIV/AIDS strategic plan has a specific section that specifies the private sector's role in the HIV/AIDS response. <input checked="" type="checkbox"/> A recent (within past 4 years) market analysis informs the private sector strategy that is included in the HIV/AIDS strategic plan <input type="checkbox"/> The government and private sector effectively coordinates and executes a total market approach for HIV service delivery, which accounts for whether people are able and/or willing to pay for HIV services. | | | |
| <p>4.2 Enabling Environment for Private Corporate Contributions to HIV/AIDS Programming: Does the host country government have systems and policies in place that allow for private corporate contributions to HIV/AIDS programming?</p> | <p>Check all that apply:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Tax policies and incentives are designed to encourage corporate social responsibility efforts from companies who are contributing financial commitments and/or non-financial resources (including, but not limited to, product donations, expertise, and employee staff time). <input type="checkbox"/> The host country government has in-house expertise in contracting services to private sector corporations when appropriate and necessary (e.g., transportation and waste management). <input type="checkbox"/> The host country government has standards for reporting and sharing data across public and private sectors. <input checked="" type="checkbox"/> Regulations help ensure that workplace programs align with the national HIV/AIDS program (e.g., medical leave policies, on-site testing, on-site prevention and education, anti-discrimination policies). <input type="checkbox"/> There are strong linkage and referral networks between on-site workplace programs and public health care facilities. | <p>4.2 Score: 0.50</p> | <p>Discussion with multiple stakeholders during SID consultations</p> | |

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| <p>4.3 Enabling Environment for Private Health Service Delivery: Does the host country government have systems and policies in place that allow for private health service delivery?</p> <p>Note: Full score possible without checking all boxes.</p> | <p><input type="radio"/> A. Private health service delivery providers are not legally allowed to deliver HIV/AIDS services.</p> <p><input type="radio"/> B. The host country government plans to allow private health service delivery providers to provide HIV/AIDS services in the next two years.</p> <p><input checked="" type="radio"/> C. Private health service delivery providers are legally allowed to deliver HIV/AIDS services. In addition (check all that apply):</p> <p><input type="checkbox"/> Policies are in place to ensure that private providers receive, understand, and adhere to national guidelines/protocols for ART, and appropriate quality standards and certifications.</p> <p><input checked="" type="checkbox"/> Systems are in place for service provision and/or research reporting by private facilities to the government, including guidelines for data reporting.</p> <p><input type="checkbox"/> Joint (i.e., public-private) supervision and quality oversight of private facilities.</p> <p><input type="checkbox"/> The government offers tax deductions for private facilities delivering HIV/AIDS services.</p> <p><input type="checkbox"/> The government offers tax deductions for private training institutions.</p> <p><input checked="" type="checkbox"/> The private sector is eligible to procure HIV/AIDS and/or ART commodities via public sector procurement channels and/or national medical stores</p> <p><input type="checkbox"/> The host country government has formal contracting or service-level agreement procedures to compensate private facilities for HIV/AIDS services.</p> <p><input checked="" type="checkbox"/> HIV/AIDS services received in private facilities are eligible for reimbursement through national health insurance schemes</p> <p><input checked="" type="checkbox"/> There are open competitions for private health care providers to compete for government service contracts</p> <p><input checked="" type="checkbox"/> There is a systematic and timely process for private company registration and/or testing of new health products (e.g., drugs, diagnostic kits, medical devices, etc.) that support HIV/AIDS programming</p> <p><input type="checkbox"/> The government effectively regulates the flow of subsidized commodities into the private sector.</p> <p><input type="checkbox"/> Private Banks or lenders provide access to low interest loans prioritizing private health sector small and medium-sized enterprise (SME) development and expansion.</p> | <p>4.3 Score: 1.94</p> | <p>Discussion with multiple stakeholders during SID consultations</p> | |
|--|--|------------------------|---|--|

4.4 Private Sector Capability and Interest: Does the private sector possess the capability to support HIV/AIDS services, and do private sector stakeholders demonstrate interest in supporting the national HIV/AIDS response?

- A. The host country government does not leverage the skill sets of the private sector for the national HIV/AIDS response.
- B. The private sector does not express interest in or actively seek out opportunities to support the national HIV/AIDS response.
- C. The private sector has expertise and has expressed interest in or actively seeks out (check all that apply):
 - Market opportunities that align with and support the national HIV/AIDS response
 - Opportunities to contribute financial and/or non-financial resources to the national response (including business skills, market research, logistics, communication, research and development, product design, brand awareness, and innovation)

4.4 Score: 1.25

Discussion with multiple stakeholders during SID consultations

Private Sector Engagement Score: 5.92

| 5. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards , etc.) related to HIV/AIDS. Program and audit reports are published publicly. Efforts are made to ensure public has access to data through print distribution, websites, radio or other methods of disseminating information. | | | | Source of Data | Notes/Comments |
|--|--|-----------------|--|----------------|----------------|
| 5.1 Surveillance Data Transparency: Does the host country government ensure that national HIV/AIDS surveillance data and analyses are made available to stakeholders and general public in a timely and useful way? | <input type="radio"/> A. The host country government does not make HIV/AIDS surveillance data available to stakeholders and the general public, or they are made available more than one year after the date of collection. <input type="radio"/> B. The host country government makes HIV/AIDS surveillance data available to stakeholders and the general public within 6-12 months. <input checked="" type="radio"/> C. The host country government makes HIV/AIDS surveillance data available to stakeholders and the general public within six months. | 5.1 Score: 2.00 | Discussion with multiple stakeholders during SID consultations | | |
| 5.2 Expenditure Transparency: Does the host country government make annual HIV/AIDS expenditure data available to stakeholders and the public in a timely and useful way? | <input type="radio"/> A. The host country government does not track HIV/AIDS expenditures. <input type="radio"/> B. The host country government does not make HIV/AIDS expenditure data available to stakeholders and the general public, or they are made available more than one year after the date of expenditures. <input checked="" type="radio"/> C. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within 6-12 months after date of expenditures. <input type="radio"/> D. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within six months after expenditures. | 5.2 Score: 1.00 | National AIDS Spending Assessment (NASA) | | |

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| <p>5.3 Performance and Service Delivery Transparency: Does the host country government make annual HIV/AIDS program performance and service delivery data available to stakeholders and the public in a timely and useful way?</p> | <p>A. The host country government does not make HIV/AIDS program performance and service delivery data available to stakeholders and the general public or they are made available more than one year after the date of programming.</p> <p>B. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within 6-12 months after date of programming.</p> <p>C. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within six months after date of programming .</p> <p>At what level of detail is this performance data reported? [CHECK ALL THAT APPLY]</p> <p><input type="checkbox"/> National</p> <p><input type="checkbox"/> District</p> <p><input type="checkbox"/> Site-Level</p> | <p>5.3 Score: 0.67</p> | <p>Discussion with multiple stakeholders during SID consultations</p> | <p>Most information provided upon request with administrative limitations being imposed on access to data.</p> |
| <p>5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?</p> | <p>A. The host country government does not make any HIV/AIDS procurements.</p> <p>B. The host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available.</p> <p>C. The host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available.</p> <p>D. The host country government makes HIV/AIDS procurements, and both tender and award details available.</p> | <p>5.4 Score: 1.00</p> | <p>Discussion with multiple stakeholders during SID consultations</p> | |

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| <p>5.5 Institutionalized Education System: Is there a government agency that is explicitly responsible for providing scientifically accurate education to the public about HIV/AIDS?</p> | <p><input type="radio"/> A. There is no government institution that is responsible for this function and no other groups provide education.</p> <p><input checked="" type="radio"/> B. There is no government institution that is responsible for this function but at least one of the following provides education:</p> <p><input checked="" type="checkbox"/> Civil society</p> <p><input type="checkbox"/> Media</p> <p><input type="checkbox"/> Private sector</p> <p><input type="radio"/> C. There is a government institution that is responsible for, and is providing, scientifically accurate information on HIV/AIDS.</p> | <p>5.5 Score: 1.00</p> | <p>Discussion with multiple stakeholders during SID consultations</p> | |
| <p>Public Access to Information Score: 5.67</p> | | | | |

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN A

Domain B. National Health System and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving prevention, treatment, and care services and interventions. There is a high demand for HIV/AIDS services, which are accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and/or are affected by the HIV/AIDS epidemic.

6. Service Delivery: The host country government at national, sub-national and facility levels facilitates planning and management of, access to and linkages between facility- and community-based HIV services.

| | | Data Source | Notes/Comments |
|--|---|---|---|
| <p>6.1 Responsiveness of facility-based services to demand for HIV services: Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)</p> | <input checked="" type="checkbox"/> Public facilities are able to tailor services to accommodate demand (e.g., modify or add hours/days of operations; add/second additional staff during periods of high patient influx; customize scope of HIV services offered; adapt organization/model of service deliver to patient flow) <input checked="" type="checkbox"/> Public facilities are able to situate services in proximity to high-HIV burden locations or populations (e.g., mobile clinics) <input checked="" type="checkbox"/> There is evidence that public facilities in high burden areas and/or serving high-burden populations generate demand for HIV services | <p>6.1 Score: 0.95</p> <p>Discussion with multiple stakeholders during SID consultations</p> | |
| <p>6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services? (Check all that apply.)</p> | <p>The host country has standardized the following design and implementation components of community-based HIV/AIDS services through (check all that apply):</p> <input type="checkbox"/> Formalized mechanisms of participation by communities, high-burden populations and/or civil society engagement in delivery or oversight of services <input checked="" type="checkbox"/> National guidelines detailing how to operationalize HIV/AIDS services in communities <input checked="" type="checkbox"/> Providing official recognition to skilled human resources (e.g. community health workers) working and delivering HIV services in communities <input checked="" type="checkbox"/> Providing financial support for community-based services <input checked="" type="checkbox"/> Providing supply chain support for community-based services <input type="checkbox"/> Supporting linkages between facility- and community-based services through <input checked="" type="checkbox"/> formalized bidirectional referral services (e.g., use of national reporting systems to refer and monitor referrals for completeness) | <p>6.2 Score: 0.79</p> <p>1. Zimbabwe National HIV/AIDS Strategic Plan (ZNASP) III Extended Version (2015-2020) 2. National Health Strategy</p> | <p>There are coordinated approaches for community interventions but these are not formalized at the national level. Work towards formalization is pending within the Ministry. Formalization of approaches for community cadre and organizations remains a challenge. The technical working group under the Nursing directorate is working on this. There is a process that recognizes the VHW but doesn't include a lot of other cadres in the community (eg. community home based care givers, BCF, etc). Financing needs to encompass the community cadre that is not necessarily under the MOHCC.</p> |
| <p>6.3 Domestic Financing of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services (i.e. excluding any external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)</p> | <input type="radio"/> A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services <input type="radio"/> B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services <input checked="" type="radio"/> C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services <input type="radio"/> D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services <input type="radio"/> E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services | <p>6.3 Score: 0.83</p> <p>National Health Funding Reports</p> | |

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| <p>6.4 Domestic Provision of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services without external technical assistance from donors?</p> | <p><input type="radio"/> A. HIV/AIDS services are primarily delivered by external agencies, organizations, or institutions.</p> <p><input type="radio"/> B. Host country institutions deliver HIV/AIDS services but with substantial external technical assistance.</p> <p><input checked="" type="radio"/> C. Host country institutions deliver HIV/AIDS services with some external technical assistance.</p> <p><input type="radio"/> D. Host country institutions deliver HIV/AIDS services with minimal or no external technical assistance.</p> | <p>6.4 Score: 0.63</p> | <p>Annual Report</p> | |
| <p>6.5 Domestic Financing of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services to key populations (i.e. without external financial assistance from donors)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p> | <p><input type="radio"/> A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations, or information is not available.</p> <p><input type="radio"/> B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations.</p> <p><input checked="" type="radio"/> C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations.</p> <p><input type="radio"/> D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations.</p> <p><input type="radio"/> E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations.</p> | <p>6.5 Score: 0.83</p> | <p>National Health Funding Reports</p> | |
| <p>6.6 Domestic Provision of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services to key populations without external technical assistance from donors?</p> | <p><input type="radio"/> A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions.</p> <p><input type="radio"/> B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance.</p> <p><input checked="" type="radio"/> C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance.</p> <p><input type="radio"/> D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.</p> | <p>6.6 Score: 0.63</p> | <p>National Health Funding Reports</p> | |
| <p>6.7 Management and Monitoring of HIV Service Delivery: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV service delivery activities including practice standards, quality, health outcomes, and information monitoring across all sectors. <u>Select only ONE answer.</u></p> | <p><input type="radio"/> A. No, there is no entity.</p> <p><input type="radio"/> B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget.</p> <p><input checked="" type="radio"/> C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget.</p> <p><input type="radio"/> D. Yes, there is an entity with authority and sufficient staff and budget.</p> | <p>6.7 Score: 0.63</p> | <p>Discussion with multiple stakeholders during SID consultations</p> | |

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| <p>6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?</p> | <p>National health authorities (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. <input checked="" type="checkbox"/> Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. <input type="checkbox"/> Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. <input type="checkbox"/> Develop sub-national level budgets that allocate resources to high burden service delivery locations. <input checked="" type="checkbox"/> Effectively engage with civil society in program planning and evaluation of services. <input checked="" type="checkbox"/> Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or | <p>6.8 Score: 0.63</p> | <p>Discussion with multiple stakeholders during SID consultations</p> | <p>An area for improvement is in the use of national data.</p> |
| <p>6.9 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?</p> | <p>Sub-national health authorities (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. <input checked="" type="checkbox"/> Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. <input type="checkbox"/> Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. <input checked="" type="checkbox"/> Develop sub-national level budgets that allocate resources to high burden service delivery locations. <input checked="" type="checkbox"/> Effectively engage with civil society in program planning and evaluation of services. <input checked="" type="checkbox"/> Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship. | <p>6.9 Score: 0.79</p> | <p>Discussion with multiple stakeholders during SID consultations</p> | |
| <p>Service Delivery Score</p> | | <p>6.75</p> | | |

| | | | Data Source | Notes/Comments |
|---|---|------------------------|--|----------------|
| <p>7. Health Workforce: Health workforce staffing decisions for those working on HIV/AIDS are based on use of workforce data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.</p> | | | | |
| <p>7.1 Health Workforce Supply: To what extent is the clinical health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or community site level?</p> | <p>Check all that apply:</p> <p><input checked="" type="checkbox"/> The country's pre-service education institutions are producing an adequate supply and skills mix of clinical health care providers</p> <p><input type="checkbox"/> The country's clinical health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden</p> <p><input checked="" type="checkbox"/> The country has developed retention schemes that address clinical health worker vacancy or attrition in high HIV burden areas</p> <p><input type="checkbox"/> The country's pre-service education institutions are producing an adequate supply and appropriate skills mix of social service workers to deliver social services to vulnerable children</p> | <p>7.1 Score: 0.71</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | |
| <p>7.2 Role of Community-based Health Workers (CHWs): To what extent are community-based health workers' roles and responsibilities specified for HIV/AIDS service delivery?</p> | <p>Check all that apply:</p> <p><input type="checkbox"/> There is a national community-based health worker (CHW) cadre that has a defined role in HIV/AIDS service delivery (e.g., through a national strategy or task-sharing framework/guidelines).</p> <p><input checked="" type="checkbox"/> Data are made available on the staffing and deployment of CHWs, including non-formalized CHWs supported by donors.</p> <p><input checked="" type="checkbox"/> The host country government officially recognizes non-formalized CHWs delivering HIV/AIDS services.</p> | <p>7.2 Score: 0.95</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | |
| <p>7.3 Health Workforce Transition: What is the status of transitioning PEPFAR and/or other donor supported HIV/AIDS health worker salaries to local financing/compensation?</p> <p>Note in comments column which donors have transition plans in place and timeline for transition.</p> | <p><input type="radio"/> A. There is no inventory or plan for transition of donor-supported health workers</p> <p><input checked="" type="radio"/> B. There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support</p> <p><input type="radio"/> C. There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented</p> <p><input type="radio"/> D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan</p> <p><input type="radio"/> E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated</p> | <p>7.3 Score: 0.24</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | |

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| <p>7.4 Domestic Funding for Health Workforce: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are supported with domestic public or private resources (i.e. excluding donor resources)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p> | <p><input type="radio"/> A. Host country institutions provide no (0%) health worker salaries</p> <p><input type="radio"/> B. Host country institutions provide minimal (approx. 1-9%) health worker salaries</p> <p><input type="radio"/> C. Host country institutions provide some (approx. 10-49%) health worker salaries</p> <p><input type="radio"/> D. Host country institutions provide most (approx. 50-89%) health worker salaries</p> <p><input checked="" type="radio"/> E. Host country institutions provide all or almost all (approx. 90%+) health worker salaries</p> | <p>7.4 Score: 3.33</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> |
| <p>7.5 Pre-service Training: Do current pre-service education curricula for any health workers providing HIV/AIDS services include HIV content that has been updated in last three years?</p> <p>Note: List applicable cadres in the comments column.</p> | <p><input type="radio"/> A. Pre-service education institutions do not have HIV content, or HIV content used by pre-service education institutions is out of date (not updated within 3 years)</p> <p><input checked="" type="radio"/> B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply):</p> <p><input checked="" type="checkbox"/> Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services</p> <p><input checked="" type="checkbox"/> Institutions maintain process for continuously updating content, including HIV/AIDS content</p> <p><input type="checkbox"/> Updated curricula contain training related to stigma & discrimination of PLHIV</p> <p><input type="checkbox"/> Institutions track student employment after graduation to inform planning</p> | <p>7.5 Score: 0.71</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> |
| <p>7.6 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p> | <p>Check all that apply among A, B, C, D:</p> <p><input checked="" type="checkbox"/> A. The host country government provides the following support for in-service training in the country (check ONE):</p> <p><input type="checkbox"/> Host country government implements no (0%) HIV/AIDS related in-service training</p> <p><input type="checkbox"/> Host country government implements minimal (approx. 1-9%) HIV/AIDS related in-service training</p> <p><input type="checkbox"/> Host country government implements some (approx. 10-49%) HIV/AIDS in-service training</p> <p><input checked="" type="checkbox"/> Host country government implements most (approx. 50-89%) HIV/AIDS in-service training</p> <p><input type="checkbox"/> Host country government implements all or almost all (approx. 90%+) HIV/AIDS in-service training</p> <p><input checked="" type="checkbox"/> B. The host country government has a national plan for institutionalizing (establishing capacity within local institutions to deliver) donor-supported in-service training in HIV/AIDS</p> <p><input checked="" type="checkbox"/> C. The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians</p> <p><input checked="" type="checkbox"/> D. The host country government maintains a database to track training for HIV/AIDS, and allocates training based on need (e.g. focusing on high burden areas)</p> | <p>7.6 Score: 0.89</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> |

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| <p>7.7 Health Workforce Data Collection and Use: Does the country systematically collect and use health workforce data, such as through a Human Resource Information Systems (HRIS), for HIV/AIDS services and/or health workforce planning and management?</p> | <p><input type="radio"/> A. There is no HRIS in country and data on the health workforce is not collected systematically for planning and management</p> <p><input type="radio"/> B. There is no HRIS in country, but some data is collected for planning and management</p> <p><input type="checkbox"/> Registration and re-licensure data for key professionals is collected and used for planning and management</p> <p><input type="checkbox"/> MOH health worker employee data (number, cadre, and location of employment) is collected and used</p> <p><input type="checkbox"/> Routine assessments are conducted regarding health worker staffing at health facility and/or community sites</p> <p><input checked="" type="radio"/> C. There is an HRIS (an interoperable system that captures at least regulatory and deployment data on health workers) in country:</p> <p><input type="checkbox"/> The HRIS is primarily financed and managed by host country institutions</p> <p><input checked="" type="checkbox"/> There is a national strategy or approach to interoperability for HRIS</p> <p><input type="checkbox"/> The government produces HR data from the system at least annually</p> <p><input type="checkbox"/> Host country institutions use HR data from the system for planning and management (e.g. health worker deployment)</p> | <p>7.7 Score: 0.60</p> | <p>National HRIS SOP and Framework</p> | |
| <p>7.8 Management and Monitoring of Health Workforce Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for health workforce activities in HIV service delivery sites, including training, supervision, deployments, quality assurance, and others across all sectors. <u>Select only ONE answer.</u></p> | <p><input type="radio"/> A. No, there is no entity.</p> <p><input checked="" type="radio"/> B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget</p> <p><input type="radio"/> C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget.</p> <p><input type="radio"/> D. Yes, there is an entity with authority and sufficient staff and budget.</p> | <p>7.8 Score: 0.32</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | <p>Limited coordination.</p> |
| <p>Health Workforce Score:</p> | | <p>7.76</p> | | |

| 8. Commodity Security and Supply Chain: The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, diagnosis and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality. | | Data Source | Notes/Comments |
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| <p>8.1 ARV Domestic Financing: What is the estimated percentage of ARV procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds)</p> <p>(if exact or approximate percentage known, please note in Comments column)</p> | <p> <input type="radio"/> A. This information is not known. <input type="radio"/> B. No (0%) funding from domestic sources <input checked="" type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources <input type="radio"/> D. Some (approx. 10-49%) funded from domestic sources <input type="radio"/> E. Most (approx. 50 – 89%) funded from domestic sources <input type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources </p> | <p>8.1 Score: 0.21</p> | <p>Discussion with multiple stakeholders</p> <p>The GoZ has established a successful AIDS levy to procure ARVs and support other program activities. However, the value of these funds has declined over the past two years as inflation has risen and the procurement of ARVs, HIV rapid test kits, and condoms is heavily dependent on donor funding. National contributions to supply chain financing are largely limited to health workforce and infrastructure. Multiple stakeholders and members from diverse CSOs expressed concern regarding a “weaknesses in the supply chain”. This concern was not regarding a reliance or dependence on donors for commodity procurement. Stakeholders were concerned about NatPharm mismanagement and poor performance when it came to the delivery of commodities to facilities.</p> |
| <p>8.2 Test Kit Domestic Financing: What is the estimated percentage of HIV Rapid Test Kit procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds)</p> <p>(if exact or approximate percentage known, please note in Comments column)</p> | <p> <input type="radio"/> A. This information is not known <input type="radio"/> B. No (0%) funding from domestic sources <input checked="" type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources <input type="radio"/> D. Some (approx. 10-49%) funded from domestic sources <input type="radio"/> E. Most (approx. 50-89%) funded from domestic sources <input type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources </p> | <p>8.2 Score: 0.21</p> | <p>Discussion with multiple stakeholders</p> |
| <p>8.3 Condom Domestic Financing: What is the estimated percentage of condom procurement funded by domestic (not donor) sources?</p> <p><i>Note:</i> The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs.</p> <p>(if exact or approximate percentage known, please note in Comments column)</p> | <p> <input type="radio"/> A. This information is not known <input checked="" type="radio"/> B. No (0%) funding from domestic sources <input type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources <input type="radio"/> D. Some (approx. 10-49%) funded from domestic sources <input type="radio"/> E. Most (approx. 50-89%) funded from domestic sources <input type="radio"/> F. All or almost all (approx. 90%+) funded from domestic sources </p> | <p>8.3 Score: 0.00</p> | <p>Discussion with multiple stakeholders</p> |

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| <p>8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?</p> | <p><input type="radio"/> A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP).</p> <p><input checked="" type="radio"/> B. There is a plan/SOP that includes the following components (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Human resources <input checked="" type="checkbox"/> Training <input checked="" type="checkbox"/> Warehousing <input checked="" type="checkbox"/> Distribution <input checked="" type="checkbox"/> Reverse Logistics <input checked="" type="checkbox"/> Waste management <input checked="" type="checkbox"/> Information system <input checked="" type="checkbox"/> Procurement <input checked="" type="checkbox"/> Forecasting <input checked="" type="checkbox"/> Supply planning and supervision <input checked="" type="checkbox"/> Site supervision | <p>8.4 Score: 1.67</p> | <p>Discussion with multiple stakeholders</p> | |
| <p>8.5 Supply Chain Plan Financing: What is the estimated percentage of financing for the supply chain plan that is provided by domestic sources (i.e. excluding donor funds)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p> | <p><input type="radio"/> A. This information is not available.</p> <p><input type="radio"/> B. No (0%) funding from domestic sources.</p> <p><input type="radio"/> C. Minimal (approx. 1-9%) funding from domestic sources.</p> <p><input checked="" type="radio"/> D. Some (approx. 10-49%) funding from domestic sources.</p> <p><input type="radio"/> E. Most (approx. 50-89%) funding from domestic sources.</p> <p><input type="radio"/> F. All or almost all (approx. 90%+) funding from domestic sources.</p> | <p>8.5 Score: 0.42</p> | <p>Discussion with multiple stakeholders</p> | |

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| <p>8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?</p> | <p>Check all that apply:</p> <p><input type="checkbox"/> The group making re-supply decisions for ARVs, have timely visibility into the ARV stock on hand at facilities</p> <p><input checked="" type="checkbox"/> Facilities are stocked with ARVs according to plan (above the minimum and below the maximum stock level) 90% of the time</p> <p><input checked="" type="checkbox"/> MOH or other host government personnel make re-supply decisions with minimal external assistance:</p> <p><input type="checkbox"/> Decision makers are not seconded or implementing partner staff</p> <p><input checked="" type="checkbox"/> Supply chain data are maintained within the Ministry of Health and not solely stored by donor-funded projects</p> <p><input checked="" type="checkbox"/> Team that conducts analysis of facility data is at least 50% host government</p> | <p>8.6 Score: 0.93</p> | <p>Discussion with multiple stakeholders</p> | <p>System has been set up but needs to be strengthened.</p> |
| <p>8.7 Assessment: Was an overall score of above 80% achieved on the National Supply Chain Assessment or top quartile for an equivalent assessment conducted within the last three years?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p> | <p><input type="radio"/> A. A comprehensive assessment has not been done within the last three years.</p> <p><input checked="" type="radio"/> B. A comprehensive assessment has been done within the last three years but the score was lower than 80% (for NSCA) or in the bottom three quartiles for the global average of other equivalent assessments</p> <p><input type="radio"/> C. A comprehensive assessment has been done within the last three years and the score was higher than 80% (for NSCA) or in the top quartile for the assessment</p> | <p>8.7 Score: 0.83</p> | <p>NSCA</p> | <p>Assessment conducted recently and score not available.</p> |
| <p>8.8 Management and Monitoring of Supply Chain: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - supply chain activities including forecasting, stock monitoring, logistics and warehousing support, and other forms of information monitoring across all sectors? <u>Select only ONE answer.</u></p> | <p><input type="radio"/> A. No, there is no entity.</p> <p><input checked="" type="radio"/> B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget</p> <p><input type="radio"/> C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget.</p> <p><input type="radio"/> D. Yes, there is an entity with authority and sufficient staff and budget.</p> | <p>8.8 Score: 0.56</p> | | <p>The systems within the body are weak and HR gaps at subnational levels.</p> |
| <p>Commodity Security and Supply Chain Score:</p> | | <p>4.81</p> | | |

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| 9. Quality Management: Host country has institutionalized quality management systems, plans, workforce capacities and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services | | | | |
| 9.1 Existence of a Quality Management (QM) System: Does the host country government support appropriate QM structures to support continuous quality improvement (QI) at national, sub-national and site levels? | <input type="radio"/> A. The host country government does not have structures or resources to support site-level continuous quality improvement <input checked="" type="radio"/> B. The host country government: Has structures with dedicated focal points or leaders (e.g., committee, focal person, working groups, teams) at the national level, sub-national level and in a majority of sites where HIV/AIDS care and services are offered that are supporting site-level continuous quality improvement <input checked="" type="checkbox"/> Has a budget line item for the QM program <input checked="" type="checkbox"/> Supports a knowledge management platform (e.g., web site) and/or peer learning opportunities available to site QI participants to gain insights from other sites and interventions | 9.1 Score: 2.00 | | |
| 9.2 Quality Management/Quality Improvement (QM/QI) Plan: Is there a current (updated within the last 2 years) QM/QI plan? (The plan may be HIV program-specific or include HIV program-specific elements in a national health sector QM/QI plan.) | <input type="radio"/> A. There is no HIV/AIDS-related QM/QI strategy <input type="radio"/> B. There is a QM/QI strategy that includes HIV/AIDS, but it is not utilized <input checked="" type="radio"/> C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements, and it is partially utilized. <input type="radio"/> D. There is a current HIV/AIDS program specific QM/QI strategy, and it is fully utilized. | 9.2 Score: 1.33 | | |
| 9.3 Performance Data Collection and Use for Improvement: Are HIV program performance measurement data systematically collected and analyzed to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting? | <input type="radio"/> A. HIV program performance measurement data are not used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting. <input checked="" type="radio"/> B. HIV program performance measurement data are used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting (check all that apply): The national quality structure has a clinical data collection system from which local performance measurement data on prioritized measures are being collected, aggregated nationally, and analyzed for local and national improvement <input checked="" type="checkbox"/> There is a system for sharing data at the national, SNU, and local level, with evidence that data is used to identify quality gaps and initiate QI activities <input checked="" type="checkbox"/> There is documentation of results of QI activities and demonstration of national HIV program improvement through sharing and implementation of best practices across HIV/AIDS sites at all levels <input checked="" type="checkbox"/> | 9.3 Score: 2.00 | | |

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| <p>9.4 Health worker capacity for QM/QI: Does the host country government ensure that the health workforce has capacities to apply modern quality improvement methods to HIV/AIDS care and services?</p> | <p><input type="radio"/> A. There is no training or recognition offered to build health workforce competency in QI.</p> <p><input checked="" type="radio"/> B. There is health workforce competency-building in QI, including:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Pre-service institutions incorporate modern quality improvement methods in curricula <input checked="" type="checkbox"/> National in-service training (IST) curricula integrate quality improvement training for members of the health workforce (including managers) who provide or support HIV/AIDS services | <p>9.4 Score: 2.00</p> | | |
| <p>9.5 Existence of QI Implementation: Does the host country government QM system use proven systematic approaches for QI?</p> | <p>The national-level QM structure:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Provides oversight to ensure continuous quality improvement in HIV/AIDS care and services <input checked="" type="checkbox"/> Regularly convenes meetings that include health services consumers <input checked="" type="checkbox"/> Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement <p>Sub-national QM structures:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services <input checked="" type="checkbox"/> Regularly convene meetings that includes health services consumers <input checked="" type="checkbox"/> Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement <p>Site-level QM structures:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement | <p>9.5 Score: 2.00</p> | | |
| <p>Quality Management Score:</p> | | <p>9.33</p> | | |

| 10. Laboratory: The host country ensures adequate funds, policies, and regulations to ensure laboratory capacity (workforce, equipment, reagents, quality) matches the services required for PLHIV. | | | |
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| | | Data Source | Notes/Comments |
| 10.1 Strategic Plan: Does the host country have a national laboratory strategic plan? | <input type="radio"/> A. There is no national laboratory strategic plan <input type="radio"/> B. National laboratory strategic plan is under development <input type="radio"/> C. National laboratory strategic plan has been developed, but not approved <input type="radio"/> D. National laboratory strategic plan has been developed and approved <input type="radio"/> E. National laboratory plan has been developed, approved, and costed <input checked="" type="radio"/> F. National laboratory strategic plan has been developed, approved, costed, and implemented | 10.1 Score: 1.33 Zimbabwe Health Laboratory Strategic Plan (2016 – 2020) | |
| 10.2 Management and Monitoring of Laboratory Services: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, purchase, and provide guidance - laboratory services at the regional and district level across all sectors? <u>Select only ONE answer.</u> | <input type="radio"/> A. No, there is no entity. <input type="radio"/> B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget <input checked="" type="radio"/> C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. <input type="radio"/> D. Yes, there is an entity with authority and sufficient staff and budget. | 10.2 Score: 0.89 Ministry of Health Department of Laboratory Services (DLS) | DLS is currently understaffed taking into account the various laboratory functions |
| 10.3 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites? (if exact or approximate percentage known, please note in Comments column) | <input type="radio"/> A. Regulations do not exist to monitor minimum quality of laboratories in the country. <input type="radio"/> B. Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated). <input type="radio"/> C. Regulations exist, but are minimally implemented (approx. 1-9% of laboratories and POCT sites regulated). <input type="radio"/> D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated). <input checked="" type="radio"/> E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated). <input type="radio"/> F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated). | 10.3 Score: 1.00 Quality manuals and test/process specific SOPs are available on site. PEPFAR supported labs have SLIPTA audits conducted each year to assess and improve overall QMS as laboratories work towards accreditation | 7/13 Viral Load Labs have been approved for ISO15189 Accreditation |
| 10.4 Capacity of Laboratory Workforce: Does the host country have an adequate number of qualified laboratory personnel (human resources [HR]) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression? | <input type="radio"/> A. There are not adequate qualified laboratory personnel to achieve sustained epidemic control <input checked="" type="radio"/> B. There are adequate qualified laboratory personnel to perform the following key functions: <input checked="" type="checkbox"/> HIV diagnosis by rapid testing and point-of-care testing <input checked="" type="checkbox"/> Routine laboratory testing, including chemistry, hematology, microbiology, serology, blood banking, and malaria <input checked="" type="checkbox"/> Complex laboratory testing, including HIV viral load, CD4 testing, and molecular assays <input checked="" type="checkbox"/> TB diagnosis | 10.4 Score: 1.33 Health Services Board Departments of laboratory services (DLS) workplans (National, Provincial, District) | |

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| <p>10.5 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?</p> | <p><input type="radio"/> A. There is not sufficient infrastructure to test for viral load.</p> <p><input checked="" type="radio"/> B. There is sufficient infrastructure to test for viral load, including:</p> <p><input checked="" type="checkbox"/> Sufficient HIV viral load instruments</p> <p><input checked="" type="checkbox"/> All HIV viral load laboratories have an instrument maintenance program</p> <p><input type="checkbox"/> Sufficient supply chain system is in place to prevent stock out</p> <p><input type="checkbox"/> Adequate specimen transport system and timely return of results</p> | <p>10.5 Score: 0.67</p> | <p>National Viral Load Scale up plan (2018-2020)</p> <p>Laboratory Logistics Unit Annual National Quantification Report</p> <p>PEPFAR Lab IP Equipment inventory list</p> | |
| <p>10.6 Domestic Funds for Laboratories: To what extent are laboratory services financed by domestic public or private resources (i.e. excluding external donor funding)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p> | <p><input type="radio"/> A. No (0%) laboratory services are financed by domestic resources.</p> <p><input type="radio"/> B. Minimal (approx. 1-9%) laboratory services are financed by domestic resources.</p> <p><input checked="" type="radio"/> C. Some (approx. 10-49%) laboratory services are financed by domestic resources.</p> <p><input type="radio"/> D. Most (approx. 50-89%) laboratory services are financed by domestic resources.</p> <p><input type="radio"/> E. All or almost all (approx. 90%+) laboratory services are financed by domestic resources.</p> | <p>10.6 Score: 1.67</p> | <p>GoZ Health Budgets (Lab)</p> <p>Global Fund funding Commitments</p> <p>PEPFAR SDS/FAST</p> | |
| Laboratory Score: | | 6.89 | | |

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B

Domain C. Strategic Financing and Market Openness

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments. Finally, having and effectively implementing policies that ensure leveraging markets (both nonprofit and for profit) where appropriate and enabling their participation and competition will be critical for a sustained HIV response.

| Fiscal Context for Health and HIV/AIDS | | Data Source | Notes/Comments |
|---|---------|--|---|
| This section will not be assigned a score, but will provide additional contextual information to complement the questions in Domain C. | | | |
| 1. What percentage of general government expenditures goes to health? | 9% | 2015 National Health Accounts (NHA) | The government consistently fails to meet the Abuja declaration and the value of funding allocation continues to decline. |
| 2. What is the per capita health expenditure all sources? | \$29.00 | Zimbabwe Public Health Expenditure Report 2015 | |
| 3. What is the total health care expenditure all sources as a percent of GDP? | 10.34% | 2015 National Health Accounts (NHA) | |
| 4. What percent of total health expenditures is financed by external resources? | 43.00% | 2015 National Health Accounts (NHA) | |
| 5. What percent of total health expenditures is financed by out of pocket spending net of household contributions to medical schemes/pre-payment schemes? | 36.00% | Zimbabwe Public Health Expenditure Report 2015 | This figure has been increasing over the years due to worsening socio economic situation in the country |

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| <p>11.2 Domestic Budget: To what extent does the national budget explicitly account for the national HIV/AIDS response?</p> | <p><input type="radio"/> A. There is no explicit funding for HIV/AIDS in the national budget.</p> <p><input checked="" type="radio"/> B. There is explicit HIV/AIDS funding within the national budget.</p> <p><input checked="" type="checkbox"/> The HIV/AIDS budget is program-based across ministries</p> <p><input checked="" type="checkbox"/> The budget includes or references indicators of progress toward national HIV/AIDS strategy goals</p> <p><input checked="" type="checkbox"/> The budget includes specific HIV/AIDS service delivery targets</p> <p><input type="checkbox"/> National budget reflects all sources of funding for HIV, including from external donors</p> | <p>11.2 Score: 0.83</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | <p>MOHCC is implementing program based budgeting. The indicators are there, but funds have not been tied to specific target goals/indicators.</p> |
| <p>11.3 Annual Goals/Targets: To what extent does the national budget contain HIV/AIDS goals/targets?</p> | <p><input type="radio"/> A. There are no HIV/AIDS goals/targets articulated in the national budget</p> <p><input checked="" type="radio"/> B. There are HIV/AIDS goals/targets articulated in the national budget.</p> <p><input checked="" type="checkbox"/> The goals/targets are measurable.</p> <p><input type="checkbox"/> Budget items/programs are linked to goals/targets.</p> <p><input checked="" type="checkbox"/> The goals/targets are routinely monitored during budget execution.</p> <p><input checked="" type="checkbox"/> The goals/targets are routinely monitored during the development of the budget.</p> | <p>11.3 Score: 0.83</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | <p>MODO meetings; PS presentation to MOFED</p> |
| <p>11.4 HIV/AIDS Budget Execution: For the previous three years, what was the average execution rate for budgeted domestic HIV/AIDS resources (i.e. excluding any donor funds) at both the national and subnational level?</p> <p>(If subnational data does not exist or is not available, answer the question for the national level. Note level covered in the comments column)</p> | <p><input type="radio"/> A. There is no HIV/AIDS budget, or information is not available.</p> <p><input type="radio"/> B. 0-49% of budget executed</p> <p><input type="radio"/> C. 50-69% of budget executed</p> <p><input type="radio"/> D. 70-89% of budget executed</p> <p><input checked="" type="radio"/> E. 90% or greater of budget executed</p> | <p>11.4 Score: 0.95</p> | <p>MOHCC Resource Mapping 2016-2020</p> | <p>Reviewed HIV funding budgets in 2017 and compared it to the expenditure data collected in 2018.</p> |

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| <p>11.5 Donor Spending: Does the Ministry of Health or Ministry of Finance routinely, and at least on an annual basis, collect all donor spending in the health sector or for HIV/AIDS-specific services?</p> | <p><input type="radio"/> A. Neither the Ministry of Health nor the Ministry of Finance routinely collects all donor spending in the health sector or for HIV/AIDS-specific services.</p> <p><input type="radio"/> B. The Ministry of Health or Ministry of Finance routinely collects all donor spending for only HIV/AIDS-specific services.</p> <p><input checked="" type="radio"/> C. The Ministry of Health or Ministry of Finance routinely collects all donor spending all the entire health sector, including HIV/AIDS-specific services.</p> | <p>11.5 Score: 0.95</p> | <p>Resource Mapping Report</p> | |
| <p>11.6 Domestic Spending: What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding? (Domestic funding excludes out-of-pocket, Global Fund grants, and other donor resources)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p> | <p><input type="radio"/> A. None (0%) is financed with domestic funding.</p> <p><input type="radio"/> B. Very little (approx. 1-9%) is financed with domestic funding.</p> <p><input checked="" type="radio"/> C. Some (approx. 10-49%) is financed with domestic funding.</p> <p><input type="radio"/> D. Most (approx. 50-89%) is financed with domestic funding.</p> <p><input type="radio"/> E. All or almost all (approx. 90%+) is financed with domestic funding.</p> | <p>11.6 Score: 1.67</p> | <p>National AIDS Spending Assessment 2018</p> | |
| <p>11.7 Health Budget Execution: What was the country's execution rate of its budget for health in the most recent year's budget?</p> | <p><input type="radio"/> A. There is no budget for health or no money was allocated.</p> <p><input type="radio"/> B. 0-49% of budget executed.</p> <p><input type="radio"/> C. 50-69% of budget executed.</p> <p><input checked="" type="radio"/> D. 70-89% of budget executed.</p> <p><input type="radio"/> E. 90% or greater of budget executed.</p> | <p>11.7 Score: 0.63</p> | <p>Resource Mapping Report and Database</p> | |
| <p>11.8 Data-Driven Reprogramming: Do host country government policies/systems allow for reprogramming domestic investments based on new or updated program data during the government funding cycle?</p> | <p><input type="radio"/> A. There is no system for funding cycle reprogramming.</p> <p><input type="radio"/> B. There is a policy/system that allows for funding cycle reprogramming, but is seldom used.</p> <p><input type="radio"/> C. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy, but not based on data.</p> <p><input checked="" type="radio"/> D. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy, and is based on data.</p> | <p>11.8 Score: 0.95</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | <p>MODO Meetings, CCM</p> |
| <p>Domestic Resource Mobilization Score:</p> | | <p>7.58</p> | | |

| 12. Technical and Allocative Efficiencies: The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time). Unit costs are tracked and steps are taken to improve HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources). | | | |
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| | | | Data Source |
| | | | Notes/Comments |
| <p>12.1 Resource Allocation Process: Does the partner country government utilize a recognized data-driven model to inform the allocation of domestic (i.e. non-donor) public HIV resources?</p> <p>If yes, please note in the comments section when the model was last used and for what purpose (e.g., for Global Fund concept note development)</p> <p>(note: full score achieved by selecting one checkbox)</p> | <p>A. The host country government does not use one of the mechanisms listed below to inform the allocation of their resources.</p> <p><input type="radio"/></p> <p>B. The host country government does use the following mechanisms to inform the allocation of their resources (check all that apply):</p> <p><input checked="" type="checkbox"/> Optima</p> <p><input checked="" type="checkbox"/> Spectrum (including EPP and Goals)</p> <p><input type="checkbox"/> AIDS Epidemic Model (AEM)</p> <p><input checked="" type="checkbox"/> Modes of Transmission (MOT) Model</p> <p><input checked="" type="checkbox"/> Other recognized process or model (specify in notes column)</p> | <p>12.1 Score: 2.00</p> | <p>Spectrum Estimates; Modes of Transmission Model</p> |
| <p>12.2 Geographic Allocation: Of central government HIV-specific resources (excluding any donor funds) allocated to geographic subunits in the most recent year available, what percentage is being allocated in the highest burden geographic areas (i.e. districts that cumulatively account for 80% of PLHIV)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p> | <p><input type="radio"/> A. Information not available.</p> <p><input type="radio"/> B. No resources (0%) are targeting the highest burden geographic areas.</p> <p><input type="radio"/> C. Minimal resources (approx. 1-9%) are targeting the highest burden geographic areas.</p> <p><input checked="" type="radio"/> D. Some resources (approx. 10-49%) are targeting the highest burden geographic areas.</p> <p><input type="radio"/> E. Most resources (approx. 50-89%) are targeting the highest burden geographic areas.</p> <p><input type="radio"/> F. All or almost all resources (approx. 90%+) are targeting the highest burden geographic areas.</p> | <p>12.2 Score: 1.00</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> |

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| <p>12.3 Information on cost of service provision: Does the host country government have a system that routinely produces information on the costs of providing HIV/AIDS services, and is this information used for budgeting or planning purposes? (note: full score can be achieved without checking all disaggregate boxes).</p> | <p><input type="radio"/> A. The host country DOES NOT have a system that routinely produces information on the costs of providing HIV/AIDS services.</p> <p><input type="radio"/> B. The host country has a system that routinely produces information on the costs of providing HIV/AIDS services, but this information is not used for budgeting or planning.</p> <p><input checked="" type="radio"/> C. The host country has a system that routinely produces information on the costs of providing HIV/AIDS services AND this information is used for budgeting or planning purposes for the following services (check all that apply):</p> <p><input checked="" type="checkbox"/> HIV Testing</p> <p><input checked="" type="checkbox"/> Laboratory services</p> <p><input checked="" type="checkbox"/> ART</p> <p><input checked="" type="checkbox"/> PMTCT</p> <p><input checked="" type="checkbox"/> VMMC</p> <p><input type="checkbox"/> OVC Service Package</p> <p><input checked="" type="checkbox"/> Key population Interventions</p> <p><input checked="" type="checkbox"/> PrEP</p> | <p>12.3 Score: 2.00</p> | <p>NHS One health Costing Report MOHCC Program Strategies Optima Matrix</p> |
| <p>12.4 Improving Efficiency: Has the partner country achieved any of the following efficiency improvements through actions taken within the last three years?</p> | <p>Check all that apply:</p> <p><input checked="" type="checkbox"/> Improved operations or interventions based on the findings of cost-effectiveness or efficiency studies</p> <p><input type="checkbox"/> Reduced overhead costs by streamlining management</p> <p><input checked="" type="checkbox"/> Lowered unit costs by reducing fragmentation, i.e. pooled procurement, resource pooling, etc.</p> <p><input checked="" type="checkbox"/> Improved procurement competition</p> <p><input type="checkbox"/> Integrated HIV/AIDS into national or subnational insurance schemes (private or public -- need not be within last three years)</p> <p><input checked="" type="checkbox"/> Integrated HIV into primary care services with linkages to specialist care (need not be within last three years)</p> <p><input checked="" type="checkbox"/> Integrated TB and HIV services, including ART initiation in TB treatment settings and TB screening and treatment in HIV care settings (need not be within last three years)</p> | <p>12.4 Score: 1.56</p> | <p>SR-HIV Integration Analysis Report, TB/HIV Service Delivery Integration</p> |

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| | <p><input checked="" type="checkbox"/> Integrated HIV and MCH services, including ART initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings (need not be within last three years)</p> <p><input checked="" type="checkbox"/> Developed and implemented other new and more efficient models of HIV service delivery (e.g., multi-month scripting, testing modalities targeted to the population profile, etc. - specify in comments)</p> | | | |
| <p>12.5 ARV Benchmark prices: How do the costs of ARVs (most common first line regimen) purchased in the previous year by the partner government using domestic resources compare to international benchmark prices for that year?</p> <p>(Use the "factory cost" of purchased commodities, excluding transport costs, distribution costs, etc.)</p> | <p><input type="radio"/> A. Partner government did not pay for any ARVs using domestic resources in the previous year.</p> <p><input type="radio"/> B. Average price paid for ARVs by the partner government in the previous year was more than 50% greater than the international benchmark price for that regimen.</p> <p><input type="radio"/> C. Average price paid for ARVs by the partner government in the previous year was 10-50% greater than the international benchmark price for that regimen.</p> <p><input type="radio"/> D. Average price paid for ARVs by the partner government in the previous year was 1-10% greater than the international benchmark price for that regimen.</p> <p><input checked="" type="radio"/> E. Average price paid for ARVs by the partner government in the previous year was below or equal to the international benchmark price for that regimen.</p> | <p>12.5 Score: 2.00</p> | <p>Zimbabwe is included in the global pooled procurement for ARVs</p> | |
| <p>Technical and Allocative Efficiencies Score:</p> | | <p>8.56</p> | | |

| 13. Market Openness: Host country and donor policies do not negatively distort the market for HIV services by reducing participation and/or competition. | | | |
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| Data Source | Notes/Comments | | |
| Discussion with multiple stakeholders during SID consultations. | <p>Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies:</p> <p>A. Restrict the provision of any one aspect of HIV prevention, testing, counseling, or treatment services to a single entity (i.e., creating a monopoly arrangement for that service)?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> <p>B. Mandate that only government facilities have the exclusive right to provide any one aspect of HIV prevention, testing, counseling, or treatment services?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> <p>C. Grant exclusive rights to government institutions for providing health service training?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> | 13.1 Score: | 0.36 |
| Discussion with multiple stakeholders during SID consultations. | <p>A. Are health facilities required to obtain a government-mandated license or accreditation in order to provide HIV services? [SELECT ONE]</p> <p><input type="checkbox"/> No</p> <p>Yes, and the enforcement of the accreditation places equal <input checked="" type="checkbox"/> burden on nongovernment facilities (e.g., FBOs, CBOs, or private sector) and government facilities.</p> <p>Yes, and the enforcement of the accreditation places higher <input type="checkbox"/> burden on nongovernment facilities (e.g., FBOs, CBOs, or private sector) than on government facilities.</p> <p>B. Are health training institutions required to obtain a government-mandated license or accreditation in order to provide health service training? [SELECT ONE]</p> <p><input type="checkbox"/> No</p> <p>Yes, and the enforcement of the accreditation places equal <input checked="" type="checkbox"/> burden on nongovernment institutions (e.g., FBOs, CBOs, or private sector) and government institutions.</p> <p>Yes, and the enforcement of the accreditation places higher <input type="checkbox"/> burden on nongovernment institutions (e.g., FBOs, CBOs, or private sector) than on government institutions.</p> | 13.2 Score: | 0.36 |

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| <p>13.3 Limiting provision of certain direct clinical services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed, local providers to provide certain direct clinical services?</p> | <p>National government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed, local health service providers to offer the following HIV services:</p> <p><input type="checkbox"/> Prevention</p> <p><input type="checkbox"/> Testing and Counseling</p> <p><input type="checkbox"/> Treatment</p> | <p>13.3 Score: 0.36</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | <p>No limits as long as certain legal requirements and regulations are adhered to.</p> |
| <p>13.4 Limiting provision of certain clinical support services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed local providers to provide certain clinical support services?</p> | <p>A. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of licensed, local institutions from providing essential HIV laboratory services?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> <p>B. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create monopoly arrangements in lab testing (i.e., arrangements where effectively only one lab service provider is allowed to conduct a certain essential HIV lab service)?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> <p>C. National government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of licensed, local institutions from procuring or distributing the following HIV commodities and supplies [PLEASE SPECIFY TYPE IN NOTES]:</p> <p><input type="checkbox"/> ARVs</p> <p><input type="checkbox"/> Test kits</p> <p><input type="checkbox"/> Laboratory supplies</p> <p><input type="checkbox"/> Other</p> <p>D. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create monopoly supply chain arrangements for HIV commodities (i.e., arrangements where effectively only one entity is able to supply a certain essential HIV commodity)?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> | <p>13.4 Score: 0.36</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | <p>No limits as long as certain legal requirements and regulations are adhered to.</p> |

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| <p>13.5 Limits on local manufacturing: Do national government policies limit the ability of the local manufacturing industry to compete with the international market?</p> | <p>A. Do national government policies restrict the production of HIV commodities and supplies by local manufacturers beyond international standards?</p> <p><input type="radio"/> Yes</p> <p><input checked="" type="radio"/> No</p> <p>B. [IF YES] For which of the following is local manufacturing restricted?</p> <p><input type="checkbox"/> ARVs</p> <p><input type="checkbox"/> Test kits</p> <p><input type="checkbox"/> Laboratory supplies</p> <p><input type="checkbox"/> Other</p> | <p>13.5 Score: 0.36</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | |
| <p>13.6 Cost of entry/exit: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies significantly raise the cost of entry or exit by a local provider?</p> | <p>Do local health service facilities face higher start-up or maintenance costs compared to government or donor (e.g., PEPFAR, GFATM, etc.) supported facilities (e.g., lack of access to funds, higher accreditation fees, prohibitive contracting costs, etc.)?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> | <p>13.6 Score: 0.36</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | |
| <p>13.7 Geographical barriers: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create geographical barriers for local providers to supply goods, services or labor, or invest capital?</p> | <p>A. Are certain geographical areas restricted to only government or donor-supported HIV service providers?</p> <p><input type="radio"/> Yes</p> <p><input checked="" type="radio"/> No</p> <p>B. [IF YES] Which of the following are geographically restricted?</p> <p><input type="checkbox"/> Supplying HIV supplies and commodities</p> <p><input type="checkbox"/> Supplying HIV services or health workforce labor</p> <p><input type="checkbox"/> Investing capital (e.g., constructing or renovating facilities)</p> | <p>13.7 Score: 0.36</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | |
| <p>13.8 Freedom to advertise: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the freedom of local organizations to advertise or market HIV goods or services?</p> <p>[Note: "organizations" in this case can refer broadly to clinical service providers and also organizations providing advocacy and promotion services.]</p> | <p>Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the freedom of nongovernment (e.g., FBOs, CBOs, or private sector) organizations to advertise or promote HIV services either online, over TV and radio, or in public spaces?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> | <p>13.8 Score: 0.63</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | <p>The GoZ does not allow for clinical services to be advertised in the media.</p> |

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| <p>13.9 Quality standards for HIV services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies, and the enforcement of those policies, hold all HIV service providers (government-run, local private sector, FBOs, etc.) to the same standards of service quality?</p> | <p>Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies, and the enforcement of those policies, hold all HIV service providers (government-run, local private sector, FBOs, etc.) to the same standards of service quality? [CHECK ALL THAT APPLY]</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No, government service providers are held to higher standards than nongovernment service providers</p> <p><input type="checkbox"/> No, FBOs/CSOs are held to higher standards than government service providers</p> <p><input type="checkbox"/> No, private sector providers are held to higher standards than government service providers</p> | <p>13.9 Score: 0.63</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | |
| <p>13.10 Quality standards for HIV commodities: Do national government policies set standards for product quality that provide an advantage to some commodity suppliers over others?</p> | <p>Do national government policies set product quality standards on HIV commodities that advantage some suppliers over others? [IF YES, PLEASE EXPLAIN IN NOTES]</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> | <p>13.10 Score: 0.00</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | <p>Government works with international guidelines that determine the products to use (e.g. DTG as preferred regimens, type of test kits to use). Algorithms are specific.</p> |
| <p>13.11 Cost of service provision: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies significantly raise the cost of service provision for some local providers relative to others (especially by treating incumbents differently from new entrants)?</p> | <p>A. Do government HIV service providers receive greater subsidies or support of overhead expenses (e.g., operational support) as compared to nongovernment (e.g., FBOs, CBOs, or private sector) HIV service providers?</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>B. Does the national government selectively subsidize certain nongovernment (e.g., FBOs, CBOs, or private sector), local HIV service providers over others?</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>C. Do government health training institutions receive greater subsidies or support of overhead expenses as compared to nongovernment (e.g., FBOs, CBOs, or private sector) health training institutions?</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>D. Does the national government selectively subsidize certain nongovernment (e.g., FBOs, CBOs, or private sector), local health service training institutions over others?</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> | <p>13.11 Score: 0.00</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | <p>MOHCC subsidizes the Mission Hospitals salaries and overhead costs. They are a line item in MOHCC budget.</p> |

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| <p>13.12 Self-regulation: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies allow for the creation of a self-regulatory or co-regulatory regime?</p> | <p>Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies allow HIV service providers—either groups of individuals or groups of institutions—to create structural barriers (e.g., closed network systems) that may reduce the incentive of other potential providers to provide HIV services?</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> | <p>13.12 Score: 0.00</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | |
| <p>13.13 Publishing of provider information: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies require or encourage information on local providers’ outputs, prices, sales or costs to be published?</p> | <p>A. National government or donor (e.g., PEPFAR, GFATM, etc.) policies require nongovernment (e.g., FBOs, CBOs, or private sector) health service facilities to publish more data than government facilities on the following [CHECK ALL THAT APPLY]:</p> <p><input type="checkbox"/> HIV service caseload</p> <p><input type="checkbox"/> Procurement of HIV supplies/commodities</p> <p><input type="checkbox"/> Expenses</p> <p>B. National government or donor (e.g., PEPFAR, GFATM, etc.) policies require HIV commodity suppliers to publish data on the following [CHECK ALL THAT APPLY]:</p> <p><input type="checkbox"/> Distribution</p> <p><input type="checkbox"/> Sales/Revenue</p> <p><input type="checkbox"/> Production costs</p> | <p>13.13 Score: 1.25</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | |
| <p>13.14 Patient choice: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of patients to decide which providers or products to use?</p> | <p>Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of patients or specific groups of patients to choose:</p> <p>A. Which HIV service providers they use?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> <p>B. Which HIV supplies/commodities they use (e.g., ARVs, PrEP, condoms, needles, etc.)?</p> <p><input checked="" type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> | <p>13.14 Score: 0.63</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | |
| <p>13.15 Patient mobility: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies reduce mobility of patients between HIV service providers by increasing the explicit or implicit costs of changing providers?</p> | <p>Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies impose costs or other barriers that restrict a patient’s ability to transfer from a government HIV service provider to a nongovernment (e.g., FBO, CBO, or private sector) HIV service provider?</p> <p><input type="checkbox"/> Yes</p> <p><input checked="" type="checkbox"/> No</p> | <p>13.15 Score: 1.25</p> | <p>Discussion with multiple stakeholders during SID consultations.</p> | |
| <p>Market Openness Score:</p> | | <p>6.88</p> | | |

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN C

Domain D: Strategic Information

What Success Looks Like: Using local and national systems, the host country government collects, analyzes and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

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| <p>14. Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV, HIV incidence, HIV prevalence, viral load and AIDS-related mortality rates.</p> | | | | |
| <p>14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV/AIDS epidemiological surveys and/or surveillance activities including: data collection, analysis and interpretation; data storage and retrieval; and quality assurance across all sectors. <u>Select only ONE answer.</u></p> | <p><input type="radio"/> No, there is no entity.</p> <p><input type="radio"/> Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget</p> <p><input checked="" type="radio"/> Yes, there is an entity with authority and sufficient staff, but not a sufficient budget.</p> <p><input type="radio"/> Yes, there is an entity with authority and sufficient staff and budget.</p> | <p>14.1 Score: 0.56</p> | <p>ZimStat, MOHCC, NAC</p> | <p>ZimStat has the authority to conduct surveys across sectors. The MOHCC AIDS/TB program has the authority to conduct health surveillance activities. Both entities rely heavily on donor funding and are under resourced.</p> |
| <p>14.2 Who Leads General Population Surveys & Surveillance: To what extent does the host country government lead and manage planning and implementation of the HIV/AIDS portfolio of general population epidemiological surveys and surveillance activities (population-based household surveys, case reporting/clinical surveillance, drug resistance surveillance, etc.)?</p> | <p><input type="radio"/> A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years</p> <p><input type="radio"/> B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions</p> <p><input type="radio"/> C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies</p> <p><input checked="" type="radio"/> D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies</p> <p><input type="radio"/> E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with minimal or no technical assistance from external agencies</p> | <p>14.2 Score: 0.63</p> | <p>ZDHS, ZIMPHIA, and YAZ</p> | <p>The design and implementation of surveys is heavily supported by ZimStat and most surveys (ZDHS, MICS, YAZ) are included as part of national strategic documents. Some Surveys like ZIMPHIA are relatively new and led substantially by external agencies.</p> |
| <p>14.3 Who Leads Key Population Surveys & Surveillance: To what extent does the host country government lead & manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (IBBS, size estimation studies, etc.)?</p> | <p><input type="radio"/> A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years</p> <p><input checked="" type="radio"/> B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions</p> <p><input type="radio"/> C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies</p> <p><input type="radio"/> D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies</p> <p><input type="radio"/> E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, without minimal or no technical assistance from external agencies</p> | <p>14.3 Score: 0.21</p> | <p>Female Sex Worker Size Estimates MSM biobehavioural study which is currently in the data analysis stage.</p> | <p>Planning and implementation was led by external partners, but government reviewed and approved protocols through NAC, MOHCC, and MRCZ, RCZ</p> |

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| <p>14.4 Who Finances General Population Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p> | <p><input type="radio"/> A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years</p> <p><input type="radio"/> B. No financing (0%) is provided by the host country government</p> <p><input checked="" type="radio"/> C. Minimal financing (approx. 1-9%) is provided by the host country government</p> <p><input type="radio"/> D. Some financing (approx. 10-49%) is provided by the host country government</p> <p><input type="radio"/> E. Most financing (approx. 50-89%) is provided by the host country government</p> <p><input type="radio"/> F. All or almost all financing (90% +) is provided by the host country government</p> | <p>14.4 Score: 0.42</p> | <p>1. Discussion with multiple stakeholders during SID consultations. 2. Resource Mapping Databases 2016-2019</p> | <p>Host country government contribution is mostly through salaries for government staff and infrastructure.</p> |
| <p>14.5 Who Finances Key Populations Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)?</p> <p>(if exact or approximate percentage known, please note in Comments column)</p> | <p><input type="radio"/> A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years</p> <p><input checked="" type="radio"/> B. No financing (0%) is provided by the host country government</p> <p><input type="radio"/> C. Minimal financing (approx. 1-9%) is provided by the host country government</p> <p><input type="radio"/> D. Some financing (approx. 10-49%) is provided by the host country government</p> <p><input type="radio"/> E. Most financing (approx. 50-89%) is provided by the host country government</p> <p><input type="radio"/> F. All or almost all financing (approx. 90% +) is provided by the host country government</p> | <p>14.5 Score: 0.00</p> | <p>1. Discussion with multiple stakeholders during SID consultations. 2. Resource Mapping Databases 2016-2019</p> | <p>key population surveys have been financed through external agencies.</p> |

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| <p>14.6 Comprehensiveness of Prevalence and Incidence Data: To what extent does the host country government collect HIV prevalence and incidence data according to relevant disaggregation's, populations and geographic units?</p> | <p>Check ALL boxes that apply below. (A.) refers to prevalence data. (B.) refers to incidence data:</p> <p><input checked="" type="checkbox"/> A. The host country government collects at least every 5 years HIV prevalence data disaggregated by:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Age (at coarse disaggregates) <input checked="" type="checkbox"/> Age (at fine disaggregates) <input checked="" type="checkbox"/> Sex <input type="checkbox"/> Key populations (FSW, PWID, MSM, TG, prisoners) <input type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) <input checked="" type="checkbox"/> Sub-national units <p><input checked="" type="checkbox"/> B. The host country government collects at least every 5 years HIV incidence disaggregated by:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Age (at coarse disaggregates) <input checked="" type="checkbox"/> Age (at fine disaggregates) <input checked="" type="checkbox"/> Sex <input type="checkbox"/> Key populations (FSW, PWID, MSM, TG, prisoners) <input type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) <input checked="" type="checkbox"/> Sub-national units | <p>14.6 Score: 0.67</p> | <p>ZIMPHIA 2015, National HIV estimates, MOHCC program data</p> | |
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| <p>14.7 Comprehensiveness of Viral Load Coverage Data: To what extent does the host country government collect/report viral load coverage data according to relevant disaggregation's and across all PLHIV?</p> <p>(if exact or approximate percentage is known, please note in Comments column)</p> | <p><input type="radio"/> A. The host country government does not collect/report viral load coverage data or does not conduct viral load monitoring</p> <p><input checked="" type="radio"/> B. The host country government collects/reports viral load coverage data (answer both subsections below):</p> <p>Government collects/report viral load coverage data according to the following disaggregates (check ALL that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Age <input checked="" type="checkbox"/> Sex <input checked="" type="checkbox"/> Key populations (FSW, PWID, MSM, TG, prisoners) <input checked="" type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) <p>For what proportion of PLHIV does the government collect/report viral load coverage data (select one of the following):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Less than 25% <input type="checkbox"/> 25-50% <input type="checkbox"/> 50-75% <input checked="" type="checkbox"/> More than 75% | <p>14.7 Score: 0.83</p> | <p>HMIS</p> | |
| <p>14.8 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct integrated behavioral surveillance (either as a standalone IBBS or integrated into other routine surveillance such as HSS+) and size estimation studies for key and priority populations? (Note: Full score possible without selecting all disaggregates.)</p> <p>Please note most recent survey dates in comments section.</p> | <p><input type="radio"/> A. The host country government does not conduct IBBS or size estimation studies for key populations (FSW, PWID, MSM, TG, prisoners) or priority populations (Military, etc.).</p> <p><input checked="" type="radio"/> B. The host country government conducts (answer both subsections below):</p> <p>IBBS (or other integrated behavioral surveillance) for (check ALL that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Female sex workers (FSW) <input checked="" type="checkbox"/> Men who have sex with men (MSM) <input type="checkbox"/> Transgender (TG) <input type="checkbox"/> People who inject drugs (PWID) <input type="checkbox"/> Prisoners <input checked="" type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) <p>Size estimation studies for (check ALL that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Female sex workers (FSW) <input checked="" type="checkbox"/> Men who have sex with men (MSM) <input type="checkbox"/> Transgender (TG) <input type="checkbox"/> People who inject drugs (PWID) <input checked="" type="checkbox"/> Prisoners <input type="checkbox"/> Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) | <p>14.8 Score: 0.63</p> | <p>Sex worker size estimation 2017</p> | |

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| <p>14.9 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance and survey strategy (or a national surveillance and survey strategy with specifics for HIV)?</p> | <p><input type="radio"/> A. There is no national HIV surveillance and surveys strategy, or a national surveillance and surveys strategy exists but does not include specifics for HIV surveillance and surveys</p> <p><input checked="" type="radio"/> B. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), but the strategy does not outline a timeline for data collection for all relevant population groups</p> <p><input type="radio"/> C. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), and outlines a timeline for data collection for all relevant population groups</p> | <p>14.9 Score: 0.42</p> | | |
| <p>14.10 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?</p> | <p><input type="radio"/> A. No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented.</p> <p><input checked="" type="radio"/> B. The following structures, procedures or policies exist to assure quality of surveys & surveillance data (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> A national surveillance unit or other entity is responsible for assuring the quality of surveys & surveillance data <input checked="" type="checkbox"/> A national, approved surveys & surveillance strategy is in place, which outlines standards, policies and procedures for data quality assurance <input checked="" type="checkbox"/> Standard national procedures & protocols exist for reviewing surveys & surveillance data for quality and sharing feedback with appropriate staff responsible for data collection <input checked="" type="checkbox"/> An in-country internal review board (IRB) exists and reviews all protocols. | <p>14.10 Score: 0.83</p> | <p>NATIONAL RESEARCH AGENDA NAC, Medical Research Council policies</p> | |
| <p>Epidemiological and Health Data Score:</p> | | <p>5.18</p> | | |

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| 15. Financial/Expenditure data: Government collects, tracks and analyzes and makes available financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS expenditures from all financing sources, costing, and economic evaluation, efficiency and market demand analyses for cost-effectiveness. | | | | |
| 15.1 Who Leads Collection of Expenditure Data: To what extent does the host country government lead & manage a national expenditure tracking system to collect HIV/AIDS expenditure data? | <input type="radio"/> A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years <input type="radio"/> B. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), but planning and implementation is primarily led by external agencies, organizations, or institutions <input type="radio"/> C. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with substantial external technical assistance <input type="radio"/> D. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with some external technical assistance <input checked="" type="radio"/> E. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), and planning and implementation is led by the host country government, with minimal or no external technical assistance | 15.1 Score: 3.33 | NASA, Resource mapping report 2018 | |
| 15.2 Comprehensiveness of Expenditure Data: To what extent does the host country government collect HIV/AIDS public sector expenditures according to funding source, expenditure type, program and geographic area? | <input type="radio"/> A. No HIV/AIDS expenditure tracking has occurred within the past 5 years <input checked="" type="radio"/> B. HIV/AIDS expenditure data are collected (check all that apply): <input checked="" type="checkbox"/> By source of financing, such as domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others <input checked="" type="checkbox"/> By expenditures per program area, such as prevention, care, treatment, health systems strengthening <input checked="" type="checkbox"/> By type of expenditure, such as training, overhead, vehicles, supplies, commodities/reagents, personnel <input checked="" type="checkbox"/> Sub-nationally | 15.2 Score: 3.33 | NASA | |
| 15.3 Timeliness of Expenditure Data: To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions? | <input type="radio"/> A. No HIV/AIDS expenditure data are collected <input type="radio"/> B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago <input type="radio"/> C. HIV/AIDS expenditure data were collected at least once in the past 3 years <input type="radio"/> D. HIV/AIDS expenditure data are collected annually but represent more than one year of expenditures <input checked="" type="radio"/> E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures | 15.3 Score: 3.33 | Resource mapping report 2018 | |
| Financial/Expenditure Data Score: | | | 10.00 | |

| 16. Performance data: Government routinely collects, reports, analyzes and makes available HIV/AIDS service delivery data. Service delivery data are analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including linkage to care, adherence and retention, and viral load testing coverage and suppression. | | | |
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| | | Data Source | Notes/Comments |
| <p>16.1 Who Leads Collection and Reporting of Service Delivery Data: To what extent is the routine collection and reporting of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government at the national level?</p> | <p><input type="radio"/> A. No system exists for routine collection of HIV/AIDS service delivery data</p> <p><input type="radio"/> B. Multiple unharmonized or parallel information systems exist that are managed and operated separately by various government entities, local institutions and/or external agencies/institutions</p> <p><input type="radio"/> C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution</p> <p><input checked="" type="radio"/> D. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government with technical assistance from external agency/institution</p> <p><input type="radio"/> E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government</p> | <p>16.1 Score: 1.00</p> | <p>National AIDS Reporting Form (every implementer fills and submits a monthly form and is compiled quarterly by NAC). DHIS for MOHCC.</p> <p>TA support for EHR, ePMS and DHIS2</p> |
| <p>16.2 Who Finances Collection of Service Delivery Data: To what extent does the host country government finance the routine collection of HIV/AIDS service delivery data (e.g., salaries of data clerks/M&E staff, printing & distribution of paper-based tools, electronic reporting system maintenance, data quality supervision, etc.)? (if exact or approximate percentage known, please note in Comments column)</p> | <p><input type="radio"/> A. No routine collection of HIV/AIDS service delivery data exists</p> <p><input type="radio"/> B. No financing (0%) is provided by the host country government</p> <p><input type="radio"/> C. Minimal financing (approx. 1-9%) is provided by the host country government</p> <p><input checked="" type="radio"/> D. Some financing (approx. 10-49%) is provided by the host country government</p> <p><input type="radio"/> E. Most financing (approx. 50-89%) is provided by the host country government</p> <p><input type="radio"/> F. All or almost all financing (90%+) is provided by the host country government</p> | <p>16.2 Score: 1.67</p> | <p>Resource Mapping Report 2018</p> <p>Global Fund and PEPFAR provide support for electronic systems development, maintenance, and printing of paper based tools.</p> |

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| <p>16.3 Comprehensiveness of Service Delivery Data: To what extent does the host country government collect HIV/AIDS service delivery data by population, program and geographic area? (Note: Full score possible without selecting all disaggregates.)</p> | <p>Check ALL boxes that apply below:</p> <p><input checked="" type="checkbox"/> A. The host country government routinely collects & reports service delivery data for:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> HIV Testing <input checked="" type="checkbox"/> PMTCT <input checked="" type="checkbox"/> Adult Care and Support <input checked="" type="checkbox"/> Adult Treatment <input checked="" type="checkbox"/> Pediatric Care and Support <input checked="" type="checkbox"/> Orphans and Vulnerable Children <input checked="" type="checkbox"/> Voluntary Medical Male Circumcision <input checked="" type="checkbox"/> HIV Prevention <input checked="" type="checkbox"/> AIDS-related mortality <p><input checked="" type="checkbox"/> B. Service delivery data are being collected:</p> <ul style="list-style-type: none"> <input type="checkbox"/> By key population (FSW, PWID, MSM, TG, prisoners) <input type="checkbox"/> By priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) <input checked="" type="checkbox"/> By age & sex <input checked="" type="checkbox"/> From all facility sites (public, private, faith-based, etc.) <input type="checkbox"/> From all community sites (public, private, faith-based, etc.) | <p>16.3 Score: 1.22</p> | <p>National AIDS Reporting Form (every implementer fills and submits a monthly form that is compiled quarterly by NAC). DHIS for MOHCC</p> | <p>AIDS mortality is estimated from Spectrum estimates. There are vital statistics collected for deaths, but the quality of data collected is variable. Data collection from private facilities reporting through the national system remains a challenge.</p> |
| <p>16.4 Timeliness of Service Delivery Data: To what extent are HIV/AIDS service delivery data collected in a timely way to inform analysis of program performance?</p> | <p><input type="radio"/> A. The host country government does not routinely collect/report HIV/AIDS service delivery data</p> <p><input type="radio"/> B. The host country government collects & reports service delivery data annually</p> <p><input type="radio"/> C. The host country government collects & reports service delivery data semi-annually</p> <p><input checked="" type="radio"/> D. The host country government collects & reports service delivery data at least quarterly</p> | <p>16.4 Score: 1.33</p> | <p>National AIDS Reporting Form (every implementer fills and submits a monthly form that is compiled quarterly by NAC). DHIS for MOHCC</p> | <p>Data is collected monthly and aggregated quarterly at the national level for analysis and dissemination.</p> |

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| <p>16.5 Analysis of Service Delivery Data: To what extent does the host country government routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, viral suppression, AIDS-related mortality rates)?</p> | <p><input type="radio"/> A. The host country government does not routinely analyze service delivery data to measure program performance</p> <p><input checked="" type="radio"/> B. Service delivery data are being analyzed to measure program performance in the following ways (check all that apply):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Continuum of care cascade for each identified priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users), including HIV testing, linkage to care, treatment, adherence and retention, and viral load <input type="checkbox"/> Continuum of care cascade for each relevant key population (FSW, PWID, MSM, TG, prisoners), including HIV testing, linkage to care, treatment, adherence and retention, and viral load <input checked="" type="checkbox"/> Results against targets <input checked="" type="checkbox"/> Coverage or recent achievements of key treatment & prevention services (ART, PMTCT, VMMC, etc.) <input checked="" type="checkbox"/> Site-specific yield for HIV testing (HTC and PMTCT) <input checked="" type="checkbox"/> AIDS-related mortality rates <input checked="" type="checkbox"/> Variations in performance by sub-national unit <input checked="" type="checkbox"/> Creation of maps to facilitate geographic analysis | <p>16.5 Score: 1.00</p> | <p>National AIDS Reporting Form (every implementer fills and submits a monthly form that is compiled quarterly by NAC). DHIS for MOHCC</p> | |
| <p>16.6 Quality of Service Delivery Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data?</p> | <p><input type="radio"/> A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented.</p> <p><input checked="" type="radio"/> B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> A national, approved data quality strategy is in place, which outlines standards, policies and procedures for HIV/AIDS data quality assurance <input checked="" type="checkbox"/> A national protocol exists for routine (at least annual) Data Quality Audits/Assessments of key HIV program indicators, which are led and implemented by the host country government <input checked="" type="checkbox"/> Standard national procedures & protocols exist for routine data quality checks at the point of data entry <input checked="" type="checkbox"/> Data quality reports are published and shared with relevant ministries/government entities & partner organizations <input checked="" type="checkbox"/> The host country government leads routine (at least annual) data review meetings at national & subnational levels to review data quality issues and outline improvement plans | <p>16.6 Score: 1.33</p> | <p>Discussions with multiple stakeholders</p> | |
| <p>Performance Data Score:</p> | | <p>7.56</p> | | |

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|--|--|-------------|------|---|----------------|
| 17. Data for Decision-Making Ecosystem: Host country government demonstrates commitment and capacity to advance the use of data in informing government decisions and cultivating an informed, engaged civil society. | | | | | |
| 17.1 Civil Registration and Vital Statistics (CRVS): Is there a CRVS system in place that records births and deaths and is fully operational across the country? Is CRVS data made publicly available in a timely manner? | <input type="radio"/> A. No, there is not a CRVS system. <input checked="" type="radio"/> B. Yes, there is a CRVS system that... (check all that apply): <input checked="" type="checkbox"/> records births <input checked="" type="checkbox"/> records deaths <input checked="" type="checkbox"/> is fully operational across the country [IF YES] How often is CRVS data updated <u>and</u> made publicly available (select only one)? <input type="checkbox"/> A. The host country government does not make CRVS data available to the general public, or they are made available more than one year after the date of collection. <input type="checkbox"/> B. The host country government makes CRVS data available to the general public within 6-12 months. <input type="checkbox"/> C. The host country government makes CRVS data available to the general public within 6 months. | 17.1 Score: | 1.00 | Ministry of Home Affairs, Department of Registrar General | |
| 17.2 Unique Identification: Is there a national Unique Identification system that is used to track delivery of HIV/AIDS and other health services? Do national polices protect privacy of Unique ID information? | Is there a national Unique Identification system that is used to track delivery of HIV/AIDS and other health services? <input checked="" type="radio"/> A. No, there is no national Unique Identification system used to track delivery of services for HIV/AIDS or other health services. <input type="radio"/> B. Yes, there is a national Unique Identification system used to track delivery of services for HIV/AIDS, but not other health services. <input type="radio"/> C. Yes, there is a national Unique Identification system used to track delivery of services for HIV/AIDS and other health services. [IF YES to B or C] Are there national policies, procedures and systems in place that protect the security and privacy of Unique ID information? <input type="checkbox"/> Yes <input type="checkbox"/> No | 17.2 Score: | 0.00 | Discussions with multiple stakeholders | |

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|---|--|-------------------------|--|--|
| <p>17.3 Interoperability of National Administrative Data: To fully utilize all administrative data, are HIV/AIDS data and other relevant administrative data sources integrated in a data warehouse where they are joined for analysis across diseases and conditions?</p> | <p><input checked="" type="radio"/> A. No, there is no central integration of HIV/AIDS data with other relevant administrative data.</p> <p><input type="radio"/> B. Yes, national HIV/AIDS administrative data is integrated and joined with administrative data on the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> a. TB <input type="checkbox"/> b. Maternal and Child Health <input type="checkbox"/> c. Other Health Data (e.g., other communicable and non-communicable diseases) <input type="checkbox"/> d. Education <input type="checkbox"/> e. Health Systems Information (e.g., health workforce data) <input type="checkbox"/> f. Poverty and Employment <input type="checkbox"/> g. Other (specify in notes) | <p>17.3 Score: 0.00</p> | <p>Discussions with multiple stakeholders</p> | |
| <p>17.4 Census Data: Does the host country government regularly (at least every 10 years) collect and publicly disseminate census data?</p> | <p><input type="radio"/> A. No, the host country government does not collect census data at least every 10 years</p> <p><input type="radio"/> B. Yes, the host country government regularly collects census data, but does not make it available to the general public.</p> <p><input checked="" type="radio"/> C. Yes, the host country government regularly collects census data and makes it available to the general public.</p> <p>(IF YES TO C only) Data that are made available to the public are disaggregated by:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> a. Age <input checked="" type="checkbox"/> b. Sex <input checked="" type="checkbox"/> c. District | <p>17.4 Score: 2.00</p> | <p>The Zimbabwe National Statistics Agency</p> | |
| <p>17.5 Subnational Administrative Units: Are the boundaries of subnational administrative units made public (including district and site level)?</p> | <p><input type="radio"/> A. No, the country's subnational administrative boundaries are not made public.</p> <p><input type="radio"/> B. Yes, the host country government publicizes district-level boundaries, but not site-level geocodes.</p> <p><input checked="" type="radio"/> C. Yes, the host country government publicizes district-level boundaries and site-level geocodes.</p> | <p>17.5 Score: 2.00</p> | <p>Department of the Surveyor General</p> | |
| <p>Data for Decision-Making Ecosystem Score:</p> | | <p>5.00</p> | | |

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D